

The Journal
OF THE
British Homoeopathic Society

NEW SERIES

VOL. XIV.

SESSION 1905-1906

EDITED BY

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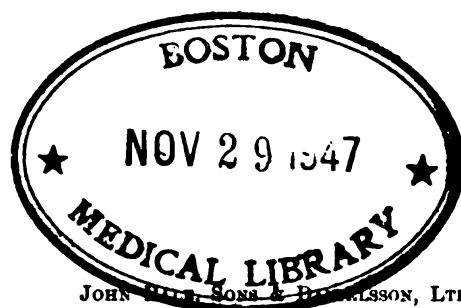
London

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1906



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NOTICE.

THIS volume comprises the Proceedings of the BRITISH HOMŒOPATHIC SOCIETY during its Sixty-first Session, 1905-1906.

The Council does not hold itself responsible for the statements, reasonings, or opinions expressed in the various Communications published in the Journal.

JOURNAL
OF THE
British Homœopathic Society

No. 1.

JANUARY, 1906.

VOL. XIV.

All communications and exchanges to be sent to

DR. GOLDSBROUGH, 82, Wimpole Street, London, W.

PROVINCIAL REFLECTIONS. A PRESIDENTIAL
ADDRESS.¹

BY ALFRED E. HAWKES, M.D., BRUX.

GENTLEMEN,—If instead of appointing me to this superlative office you had sought my advice, I could have directed your attention to a friend more fit than I am to occupy this chair without going beyond the little circle I am proud to represent on the Council of this Society. Moreover, Liverpool has lately been sending two of her most eligible men to fill respectively the chairs of the Linnæan and Gynæcological Societies, in the persons of Professor Herdman, the friend and appreciant of the lamented Isaac Thompson, and Dr. Alexander of round ligament and epileptic fame.

But I will not further disparage your choice, in view of the fact that I hope during the next few months to preside over your deliberations and, as far as I may be able, to take part in your discussions.

¹ Delivered at the Opening Meeting of the Session, 1905-6. Oct. 5, 1905.

I thank you for your confidence, and I request the help of my immediate colleagues to enable me in some sort to retain it.

In making this attempt it was open to me to study afresh the addresses that have lately emanated from this and kindred associations with a view to attempting something similar.

I have taken a more modest view of my duties, and have determined to lay before you a few thoughts—the accumulation of a third of a century—relative to the spread of homœopathy in what may be designated, in this regard at least, the second city in Great Britain.

But first permit me to remark upon the progress of the medical art during the period indicated.

During the recent celebration at the Royal College of Surgeons of Edinburgh, an able non-medical speaker, the Rev. Professor Paterson,¹ claimed that the progress of the art had been more pronounced during the latter part of the nineteenth century than during all the rest of the centuries put together.

I neither dispute nor endorse this statement, but it may be remarked that on my leaving a well-conducted laboratory, the principal of which was a relative of honoured members of this Society, in 1868, and proceeding to Glasgow, I found that Professor Penny had discarded the old combining weights, and that oxygen, carbon and calcium were no longer represented by the numbers 8, 6, and 20.

When in Glasgow, a few weeks ago, I asked during the course of conversation with a distinguished surgeon, who in my college days was a distinguished student, if he thought it probable that as students we had ever heard the term patellar reflex used? he agreed with me that probably we had not.

Ovariectomy in that day was done by the Professor of Anatomy, the clamp constituting the chief instrument of his armamentarium.

The term pyosalpinx was first used in my hearing, not by the Professor of Midwifery, but by Dr. Drysdale, and

¹ *The Scotsman*, Friday, July 21, 1905.

the said Professor of Midwifery used to exhibit a fundus uteri which had been removed not by design but by mistake, it having been diagnosed as an uterine fibroid. This may be referred to as an early and unintentional example of vaginal hysterectomy.

At this time, to the students of Glasgow, the great names of Coates, Gairdner and Lister, were familiar in their mouths as household words.

The first named had just returned from Germany, having imbibed the views of Cohnheim, to teach us of the migration of the white corpuscles and of other matters, following on the discoveries of Recklinghausen, full of interest and promise. I mention his name only as one of a trio to whose teaching I am much indebted.

The second was imbued with the often enunciated dictum, that the business of an university is to teach men how to learn—a statement which does not always commend itself to the candidate who has the fear of an examination before his eyes. In Hufeland's Journal,¹ 1796, may be found the remark that arsenic is not suitable as a medicine on account of its poisonous properties, and one of the utterances of Professor Gairdner was to the effect that while tartarated antimony did good service in pneumonia, its employment was not to be persevered with if after reducing the dose to one-sixteenth of a grain diarrhœa still resulted. A little less, and how far away from his present position of peace with honour this distinguished man might have found himself.

I do not drag in these great names to prove any thesis I may submit, but who shall say why two observers should simultaneously study the homœopathic system under the same conditions, and one practise it for the rest of his days, and the other for a like period discard its claims.

I allude to Prof. Henderson, and to a distinguished contemporary of his, who happily still lives.

At the time I refer to, Baron—then Mr.—Lister, was demonstrating that organic fluids, boiled in a Florence flask, communicating with the atmosphere by means of a con-

¹ "History of Homœopathy," by W. Ameke, M.D., p. 122.

voluted tube, could be kept without decomposing, thus following the teachings of Schwann and Pasteur.¹ He was opening abscesses under a covering of 1-20 carbolised oil. The 1-40 watery solution, the spray and carbolised plaster, as well as the necessary protective, were in full swing, and at that time his gauze was being used in such quantities as to disturb the slumbers of the Medical Superintendent of the Glasgow Royal Infirmary.

Hard by, a most daring surgeon continued to use water-dressing, and thus an object-lesson was available which he who ran—and from these wards such a mode of motion was not unknown—might read.

Subsequently to my student days corrosive sublimate came into general use, and men began to flush the peritoneal cavity with solutions of this substance, with varying results, while others allowed these solutions to trickle over the freshly-made wound.²

Gentlemen, I am not going to weary you with details with which you are more familiar than I, but you will permit me to ask, What do we find now? The living tissues are no longer deluged with these strong solutions, which, having played an heroic part in the inauguration of a new era, give place to the gentle methods of the aseptic surgeons. They have had their day, and now their place is taken, in this particular regard, by the sterilised water³ readily prepared from the almost pure products of Loch Katrine, Vyrnwy and other sources.

I may here remark that at the time referred to, 1870-1871, an excellent clinical teacher still taught that carbolic acid so acted on the oxygen of the atmosphere as to prevent putrefactive changes. The names of Liebig and Gay Lussac⁴ are associated with this phase of the question. A few simple experiments demonstrated the fallacy of this contention and secured me a house-surgeon's post. But to return. I am not about to contend that the evolution

¹ "Antiseptic Surgery," by W. W. Cheyne, M.B., F.R.C.S., p. 7, *et seq.*

² "System of Surgery," by Frederick Treves, F.R.C.S., vol. i., p. 216.

³ "Technics of Aseptic Surgery," by F. T. Paul, F.R.C.S., p. 333, No. 47, *L. M. Ch. Journal*.

⁴ "Antiseptic Surgery," by W. W. Cheyne, p. 11.

of the aseptic system, upon which I have dwelt at such length, and the methods of Hahnemann are on all fours, so to speak, nor do I affirm that the homœopathic pharmacist of to-day aims at absolute freedom from a medicament as the ultimate intention of his processes; but I have ventured to suggest that modern surgery has in one respect at least passed through the stages something very like our decimal dilutions until it has discovered—strict cleanliness being a *sine quâ non*—that water, innocent alike of medicinal admixture and disease germs, is the best application for an aseptic wound; thus first imitating, albeit unconsciously, and then transcending the Hahnemannian method. The dose question need not be discussed here, but I may remark that while we are familiar with the fact that Hahnemann rapidly ascended from the larger doses of his earlier days to the infinitesimal quantities of his later methods, we, as impartial observers cannot ignore the fact that others, of whom Dr. Drysdale may be taken as the type and example, have commenced their homœopathic studies with the higher and medium dilutions, but in their later years and in the exercise of their more mature judgment have for the most part treated their patients with more crude preparations. I should be very sorry for this observation to be looked upon as an excuse for the employment of strong preparations when others will do, and still more so if any word of mine should seem to sanction habitual alternation or the frequent use of mixtures.

Indeed, as the best definition of a homœopath I can formulate is the following, viz., the practitioner whose first impulse on seeing a patient is to search medicinal pathogenesis with a view to employing the rule of similars, so I think that he who cannot in a reasonable time permit his dosage to fall short of physiological effects should reconsider his position.

Dr. Drysdale's statement that "their whole¹ physiological action is absorbed into their therapeutic," amounts almost to a postulate. With this proviso, especially in view of recent scientific discoveries as to the division of matter,

¹ Quoted by Hughes, "Principles and Practice of Homœopathy," p. 75.

I would not tie the hands or limit the horizon of any who are called upon to deal with the most valuable temporal asset a human being possesses, viz., life.

I have referred to Dr. Drysdale, but he was only one of the early pioneers of Liverpool homœopathy, and the names of Drs. Chapman, Moore, Roche and others ought not to be omitted. My list of those who have openly practised the system in Liverpool and the immediate neighbourhood, contains the names of no fewer than seventy practitioners, and it cannot be said to be complete.

This reference to Liverpool work would be very incomplete without some remark upon the exhaustive paper on kali bichrom., by Dr. Drysdale, which, however, has been so widely availed of as to place the medicine on an equality with the polycrests, and to render further praise of this production superfluous.

About the time of Dr. Chapman's¹ death, which event not only deprived homœopathy of a faithful, if somewhat sanguine, devotee, but also of a profound classical scholar, Dr. Proctor was winning laurels for himself and our system in the poorer parts of Liverpool. His success in the cholera epidemic of 1866,² not only brought much credit to homœopathy at the time, but now, nearly forty years afterwards, very many of the poor people of the district in which the work was done are loyal homœopaths.

This brings me to another Liverpool worker, Dr. Hayward, whose article "Crotalus" in the "Materia Medica, Physiological and Applied," I think I would rather have written than any monograph on medicine I am acquainted with.

Those who have taken some pleasure in the perusal of Ovid's Metamorphosis will have read how, when the Eternal City was ravaged by plague—plague the symptoms of which are preserved to us in the following words:—

"Dira lues quondam Latias vitiaverat auras,
Pallidaque exsanguis aquarebant corpora tabo."

¹ *British Journal of Homœopathy*, vol. xxiv., pp. 174, 291.

² *British Journal of Homœopathy*, vol. xxv., p. 86.

Æsculapius in the form of a serpent, after due and solemn inquiry of the Delphic oracle himself, essayed to go to Rome to check the devastating distemper.

These lines have been variously rendered, but there is almost imparted to them the true ring of pathogenesis by Welsted, who ascribes to the words this meaning¹:—

“A wasting plague infected Latium’s skies ;
Pale, bloodless looks were seen, with ghastly eyes ;
The dire disease’s marks each visage wore,
And the pure blood was changed to putrid gore.”

How with uplifted crest he journeyed over the calm Ionian seas, touching Lacinia, passing Calabria, at length escaping Sicilian dangers to sail past the Kingdom of Æolus, by the Cape of Minerva and fruitful Campania, and

“Naples for soft delight and pleasure born,”

and so on till Tibur and Lavinium’s plains are reached, does not Ovid relate ? Finally we read :—

“Luctibus imposuit ; venitque salutifer urbi.”

Sorrows gave place, as the health-giver to the city came.

I am not about to describe the journey along the Cymric shore, or tell how sundry specimens of *Crotalus* comported themselves when passing Puffin Isle or Deva’s sands, nor must I compare the lasso with which ardent pharmacutists, Isaac Thompson among them, obtained control over these ophidians with the staff of Æsculapius :—

“Hunc modo serpentem, baculum qui nexibus ambit perspice,”

nor must I lead you to think that Liverpool as anxiously looked for this *venenum et remedium* as did ancient Rome, but you will permit me to say that this fresh supply of *crotalus*, regard being had to the difficulty of obtaining more lachesis, was most welcome, and that our thanks are due to those who obtained it.

The serpent venoms, a supply of which in several strengths I count my most valuable therapeutic asset, were introduced as medicines by Dr. Constantine Hering, and following him, others of our writers, including Drs. Hughes,

¹ A. J. Valpy, M.A., London, 1833.

Clark, and Bayes, have not been slow to elaborate indications for their employment.

Of the value of *crotalus* in scarlatina, you will find ample evidence in Dr. Hayward's monograph, and as a reserve for bad cases I have relied on it in many instances with well-placed confidence.

I was recently asked to see a case of erysipelas by one of our colleagues. The patient, an elderly man, was comatose, his face and head were dusky-red, and his pulse was very irregular. I gave my friend a choice of three drugs. Opium if he thought that cerebral symptoms predominated, cantharis if he suspected or could confirm kidney complications, and *crotalus* if he determined that we had to deal with a case of general *sapræmia*. He chose the last mentioned, and I supplied him with some 8x tincture. A few doses sufficed, and the patient soon recovered consciousness and health. I know the prognosis in erysipelas cases is not often bad, but I think there are not many remedies likely to help in such cases as this.

I must now leave the seniors and those who have borne the burden and heat of the day, leave them to rest on their laurels, and refer to more recent converts to our methods.

But alas! some of my earlier comrades are no longer with us, and the one whose name is, perhaps, as well known as any, died some years ago.

I first met Burnett to speak to on the slopes of Kelvin-side, during the Session 1871-72, and from that time until he became absorbed in London work we were much together. His references to Skoda and to Hyrtl were full of interest. On my telling him that I hoped to go to Vienna for a brief stay on finishing my college course, he assured me that nothing would please Hyrtl more than that I should take him a Scotsman's skull. I gathered that the great anatomist had skulls of all descriptions ranged round the room in which, if I mistake not, he used to work and sleep, but that the absence of the above-mentioned variety was a trouble to him, constituting a kind of *hiatus calvariae Caledoniæ*.

That skull never reached Hyrtl, but the reason was not

that I visited Martin's clinique at Berlin, instead of Hyrtl's museum at Vienna.

I must refer only to one phase of Burnett's conversion.

He had lost confidence in old physic, and did me the honour to wonder how I could believe all that he heard poured into my ear, in the wards of the Infirmary. How he read Hughes, and settled in Liverpool thirty-three years ago, and worked at the Dispensary, is known perhaps quite fully enough.

We spent most of our evenings in reading *materia medica*. His favourite mnemonic method was to allot spaces on the wall to certain groups of symptoms, and by these means he acquired a great grasp of pharmacodynamic facts.

Do you ask what became of these assorted data, to others invisible, to us indelible? It is stated that the ashes of Wyclif, on his bones being exhumed and burnt, were cast into the river Stour, and thus like his tenets—which I am not discussing—were disseminated to all points of the compass.

Burnett's observations have been deposited in the storehouse of human knowledge, whence he who feels the need can abstract them.

I am not criticising his work; how much of it will stand the test of time who can tell? But not to be familiar with his views argues a self-abnegation which is hardly commendable. Later writers will quote him, as Dr. Richard Hughes does, not so much in order to keep his memory green, as to provide for the therapeutic requirements of humanity.

A long residence in Liverpool has afforded me unusual opportunities of coming into contact with seekers after therapeutic truth. Some, before settling down to the practice of orthodox physic, have desired to look into the subject of homœopathy out of respect for—probably—a medical parent. Others have come to satisfy a curiosity as to the methods of the French doctors, a term which people from a distance would at times use in Burnett's Liverpool days.

The stages of the convert are curious and worthy of a brief reference.

Very often the enquirer has been a young practitioner, so well pleased with surgery as to have some contempt for medicine.

Several who came to us had for a long time been in the habit of ridiculing the suggestion that homœopathy could supply any want.

Indeed, if I may be excused saying so, the converts to our system of whom, had I been more instrumental than I was in their changing sides, I should have felt most proud, have been for the most part those who have had a great liking for surgery. There are three pleasures the non-medical world knows not of. The removal of the stitches from a healed wound, the clearing up of a doubtful precipitate with a drop of nitric acid, and the removal of the last obtainable vestige of retained secundines. Perhaps the greatest of these is the matter of the stitches. If by any chance there should be one here who hesitates to become a homœopath lest he should have to abandon his surgical proclivities, I may say that I do not know any place more fitting than this hospital in which to imperatively bid him, to borrow a word from your great temple, *Circumspice*.

If my memory serves me all who have come to us have yielded, and I could point to not a few scattered over our island who have remained true. I had better have said our Empire, for some occupy good positions in Britain beyond the seas. I always advise the student who has an unmistakable desire to look into homœopathy, for auto-ostracism is not to be lightly entered upon, to recall as much as he can of his toxicological studies, and such an one soon finds himself immersed, so to speak, in an environment at once new and interesting. This most interesting stage I have ventured to designate that of mimetic empiricism.

This reminds me of nothing so much as of my earliest lessons in mimicry. Indeed, do we not all remember how the minnows of our childhood's days were changed as to their hue by an alteration of their environment, say by substituting a yellow dish for the one previously occupied?

Suppose our friend comes to his appointment at the season of an epidemic. He soon finds himself employing croton, veratrum, arsenicum, china and podophyllum, remedies which in a sense are all new to him, and long before he can readily distinguish for himself by means of the repertory and materia medica, between the different drugs, he has attained a mimetic proficiency in their use. Nothing is commoner at this stage than for the student to ask with some asperity why these things have hitherto been hidden from him, and I have known the investigator to express great regret that such and such a case had not been treated by some such means. But mimicry has its pitfalls, as Mr. Steel points out in the paper to which I am indebted for this thought, viz., "Corollaries of Evolution."¹

He there relates, quoting Strabo, what dire results followed the infusion of tobacco instead of tea. The imitative act led to the death of the imitator, which fortunately in this case was only a monkey.

My hearers will not read into this narration the inference that I quite share the concern of those who dread lest they should in presenting a remedy, not the true simillimum, make an incorrigible mistake.

The expert must learn to exclaim with Addison :—

"My bane and antidote are both before me."

It is, however, a relief to the instructor when, with the help of some of the many manuals available, the therapeutic voyager is well clear of the rocks and quicksands of the mimetic stage, and is fairly launched upon the sea of pure pathogenesis.

Whether he then remains at sea in another sense depends much upon the pilot who has thus far been responsible for his embarkation.

This leads me to the reflection that our system has suffered much from the habit which some have cultivated of appropriating the hints of our writers without becoming imbued, so to speak, with the principles guiding such recommendations.

¹ *Journal of the Literary and Philosophical Society of Liverpool*, No. lvii.

In this regard the means of prescribing with scientific precision are incomplete, and the imitator is not unlike an anatomist called upon to build up a skeleton, without even the few but distinctive fragments supplied on a classical occasion to the great Owen. If any one should care to follow this thought, he will find some pretty reading at page 586, *et seq.*, of Darwin's "Origin of Species."¹ One sentence runs thus, "When the mockers and the mocked are caught and compared, they are found to be very different in essential structure, and to belong, not only to different genera, but often to distinct families." I leave this part of my subject, remarking in passing that happily the varieties amongst us do not imply other than a community of descent, and expressing the opinion that nothing can so hinder our progress as that those who strive to follow according to their light, the teachings of Hahnemann, should hold aloof from each other because they cannot all see eye to eye.

When I remind you that Drs. Berridge, Skinner and Mahoney have worked in Liverpool, and have had a following of which any section of thought might well be proud, you will concede that variety in our methods has not been wanting.

It has been stated that many have come to Liverpool to enquire into the reasonableness of homœopathy, and we cannot complain of the results of such investigations; but some have held aloof who might have been expected to cast in their lot with us.

I have frequently remarked that it says much for the straightforwardness of members of our calling that so few have been attracted by the mere salary, and that so very few have offered themselves as candidates for posts, the stipends attaching to which would have in the circumstances been very useful.

It has been my lot to attend at the homes of three families in Liverpool, members of which ultimately became brilliant representatives of the medical profession. If these men had followed the teachings of their home life, as some of us have

¹ "Origin of Species," p. 51 : John Murray, 1902.

done, such a step would have had far-reaching influence on the status of homœopathy in this country.

I cannot conceive of anything more attractive than the application of the highest culture to the healing art ; and to follow through all their potentialities for good the actions of such substances as belladonna, arsenic, and sepia, may well occupy the attention of men of the highest attainments.

Many such occupy positions amongst us to-day, and we must appeal to our gifted brethren to continue to demonstrate to the indifferent and to those who more actively oppose our tenets, that the highest culture is not incompatible with a belief in the rule we follow.

I must not offer further clues to the identity of the men I have referred to. In their cases medicine, pathology and surgery monopolised talents which might well have been devoted to *materia medica*, but the pursuit of these did not involve their devotees in professional isolation.

The time may not be so far off as it seems when the Beaconsfields, Cairnses, and Whateleys of medicine, will flock to our standard.

I should like to say a word about the position of the crypto-homœopaths. I do not allude to those, of course, who in any way identify themselves with us, but to those who feel at liberty to use our remedies without acknowledgment. The matter is a difficult one to discuss, and our friends must be left to deal with truth according to their conscience. We should be the last to withhold any remedy from the sick, and we should, I think, not withhold our sympathy from those who have not the courage of their convictions. The retort,

“If thy heart fail thee do not climb at all,”

would be too severe in this instance to the statement,

“Fain would I climb but that I fear to fall.”

We may content ourselves with the cry, “Come over and help us,” but we must not spend too much time in scanning the horizon to see if they are coming towards us with their pennants flying.

This has some bearing, but not much, on the question

of the Homœopathic Directory. For myself I should be quite satisfied with the concession made to us by the Messrs. Churchill, a concession brought about through the courageous stand of the younger Drysdale. But I cannot forget that Dr. Drysdale, his father, used to ask why his name should appear, if others felt free to keep theirs back?

As to the general opposition to us on the part of the profession I have not time to speak, save to say that the opposition to the individual homœopathic practitioner seems to me to be inversely as the number practising in a given locality. There are many honourable exceptions to this, I have no doubt, and, as I am not isolated, and have not to look in vain for the best help Liverpool can afford, help the dignity of which I have always striven to maintain, I must pass from a somewhat unpalatable subject.

I have always considered it most unjust that our motives should be questioned, and I for one have hardly ever met with a man who has gained for himself a position by means of homœopathy who would not, by the exercise of similar industry, have attained a still better status in other walks of life.

It may be true that Hahnemann himself, as has been recently pointed out, made two fortunes by his practice, but Milton's *magnum opus* is not immortal because it cost its purchaser a mere bagatelle, nor is Scott's popularity due to the incidental fact that his efforts produced the pile at Abbotsford.

I do not know whom in the foregoing remarks I may be said to have catered for, but a few words to those of my audience who, like myself, are general practitioners, will now be attempted.

Anything more theoretically perfect than the system of visiting the sick poor in Liverpool, conducted by other organisations as well as our own, which, however, our dispensaries have so long carried out, can hardly be imagined.

Given an early summons, the help of a nurse, now happily so easily obtained through the Queen Victoria system, the confidence of the friends, now seldom with-

held or withdrawn, and remarkable results are often attained.

Thanks to the courtesy of Dr. Goldsbrough, my paper dealing with this subject is about to appear in the Transactions, so I need not further enlarge upon it here. It will not, however, be difficult to understand that, while our medical officers visiting in the different districts, of whom we never have fewer than four, supply us with plenty of cases, these cases are often far advanced when they reach us, thus rendering our statistics not quite so brilliant as we could wish.

For eighteen years our hospital, which everyone knows we owe to the munificence of Sir Henry Tate, has been available for serious cases drafted from our different districts, but no one pretends that we have beds enough, and the general and fever hospitals have still to be availed of to a large extent. For instance, in seventeen years we have had 205 cases of enteric fever, with 21 deaths; 204 cases of pneumonia, of which 26 died, but 3 were admitted moribund; of bronchitic cases there have been 148, with 1 death, and rheumatic patients 268, without a fatal case. For the confirmation of these figures I am indebted to my colleague, Dr. Ellis.

Locally in one small special hospital; in a special department of one large hospital, with the exception of a far-advanced case; and in one small general hospital, which I need not mention, there was no surgical mortality last year.

I do not know why I should involve myself in a possible controversy as regards the treatment of tumours, but it seems fair to say that with the single exception of the cauliflower excrescence mentioned at the Leicester Congress as apparently cured with hydrastinin, of one or two fatty tumours cured with calcaria, of some senile carcinomatous mammary tumours indefinitely retarded, and of a small hard mammary tumour disappearing under conium, my results have been very disappointing.

The results obtained by others have probably been due to the persistent use of dilutions I do not habitually employ,

and possibly to a more searching enquiry as to the individual patient's condition and symptoms.

In view of the change which has come over the teaching as to a simple tumour altering in character, I am an advocate of early operation unless the patient absolutely refuses, when I prescribe as accurately as I can.

After an operation I believe it to be good practice to give the remedy most homœopathic to the condition to prevent a recurrence.

One of the earliest cases of scirrhus of the mamma operated on in our hospital has lived till quite recently—fourteen or fifteen years—when she was carried off by cancer of the rectum. Dr. John D. Hayward was the successful operator.

In the earlier portion of this paper I alluded to a brief visit to the Gynæcological Clinic of the elder Martin at Berlin more than thirty years ago. At that time one of the colleagues of the younger Martin was practising the subcutaneous injection of ergot in the treatment of uterine fibroids. I need not refer further to that treatment, but I may remark that I have seen very many fibroids since then. In my own practice I have only seen one death due to fibroid tumour, apart from the instance in which I removed a very large tumour by the retro-peritoneal method, in the case of a poor woman whose condition was pitiable in the extreme. She died from exhaustion some days after the operation.

The other case was one in which the disease was far advanced.

Our chloroformist commenced to give the anæsthetic, but alarming symptoms supervening—the patient being the subject of hydrothorax—we had to desist, and she ultimately died from general dropsy. The tumour, which was found on examination to have undergone calcareous degeneration, was subperitoneal and could have been easily removed.

Notwithstanding the recent issue by Dr. Burton, consulting surgeon¹ to the Liverpool Hospital for Women, of a paper in which he looks hopefully on a case in which “the

¹ Bailliere, Tindall and Cox, 1905.

change of life is within reasonable distance," and in which he discourages operation in such circumstances, I must not advocate an absolutely conservative policy in this matter. I am aware that I am speaking under peculiar circumstances to-night, and that I may have to answer for my statements at the next gynæcological sectional meeting. In a word my position is this, if an operation is urgently called for, by all means get the best man available to do it, but deaths from fibroid tumours are very rare, and, if the patient will not submit, the outlook is vastly different from that, say, in a case of perforated gastric ulcer, or a strangulated hernia, where no one would be justified in holding out hope, even although once in a way, especially in regard to gastric ulcer, the unexpected may have happened. The following remarks may be held to apply to fibroid and ovarian tumours, and so far to modify our prognosis. Several years ago a patient came to the Hahnemann Hospital into which she was admitted. An expert saw her, with his usual kindness, but diagnosis was very difficult, and at that time he did not advise operation. It was easy to follow his advice, as the patient would not submit, and for years she was treated as an out-patient.

Ultimately she begged to have something done, and happening to be in the hospital at the time of the Liverpool Congress, she was seen by Dr. Johnstone, who thought the tumour could be removed. With the kind help of Dr. Cash Reed this was done. The tumour proved to be a large ovarian with a hard, brawny pedicle which had undergone malignant metamorphosis. Dr. Neatby has kindly provided us with a section of this portion of the tumour.

The patient did not live long after the operation. She left the hospital, and I attended her till her death, which was due to rapid recurrence, if such a term can be used, where complete removal was impossible. A more convenient opportunity may occur for me to show this tumour, and another successfully removed, in which a rapidly-growing ovarian underwent colloid changes, the patient some time afterwards dying from recurrence. The obvious moral is that untoward changes may occur in a tumour left to

flourish unmolested. We have all read Sir Spencer Wells on ovarian tumour, and his fearsome picture of an ovarian cyst left alone. How often does one see an ovarian tumour cause death in these days?

Recently a very excellent friend of mine died at the age of 80. I had attended her for about twenty-five years. Latterly I became aware of an abdominal tumour, and for my own sake I had a consultation with the local friend previously referred to. My friend assured me that the tumour was a fibroid, which it would be reckless to attack. The patient died some little time afterwards of apoplexy, and I took the opportunity of emptying an unilocular cyst *post mortem*. I had not previously urged an operation, although I did not see eye to eye with my friend, but here was an ovarian tumour doing no more harm apparently than an excess of omental fat. I have another case in my recollection where a multilocular ovarian in an old lady, who declined operation, gave rise to no inconvenience.

Are we therefore to leave ovarian tumours to themselves? By no means; but they do not always run a rapid and fatal course, and if the patient will not submit to operation the practitioner need not think that he is compounding a misdemeanour, if under the circumstances he prescribes according to his light.

One word as to the imperative necessity of the practitioner either diagnosing the case, whatever its nature, himself, or of obtaining, in the event of difficulty, all available help to that end. I desire now to draw attention to one or two points which would have come better after my remarks on the use of low and high dilutions, according to the discretion of the practitioner. One demand I must make, and it is this, viz., that if a homœopathic practitioner gradually finds himself trusting to higher dilutions, and the methods associated with the later years of the life of our master, he must not relinquish one jot or tittle of his diagnostic acumen.

I do not speak solely in the interests of the patient. It may not much matter to him whether an inoperable cancer, or something else, is the cause of his incurable diarrhœa:

but it matters to a supreme degree to the medical enquirer whether the report of a given case manifests a determination on the part of the prescriber to take cognisance of the totality of the symptoms, as most of us interpret that term, or otherwise.

I have recently been attending a young woman in our out-patient department with most of the symptoms of membranous dysmenorrhœa.

I deferred examination, so conclusive were the descriptions of her sufferings, until she could conveniently come into hospital.

On examination a multiple fibroid polypus, which was removed without much difficulty, proved to be the true cause of her discomfort. I may be permitted to add that it is almost equally essential to know what is likely to happen under expectant and other methods of treatment, so that we may not fall into the error of continuing a line of treatment which experience does not warrant. The use of serums in diphtheria, which I have elsewhere referred to, and the employment of hydropathy in the hyperpyrexia of rheumatic and typhoid fevers, is in my mind at the moment.

I had hoped to dwell for a minute or two on a case of icterus neonatorum due to absence of the normal bile ducts, and the birth at the next confinement of a puny child, although ante-natal medication was exhibited; and on a case of pericarditis at once difficult of diagnosis and disappointing as to treatment, in consequence of a tag of adhesion from the cardiac apex to the pericardium which prevented friction being heard, and cardiac contraction being effectual, but I must desist. Alas! too, I have failed to laud the cypher repertory, which a recent president of this Society helped to perfect, doubtless due to his stay in Liverpool.

Gentlemen, if in a moment of aberration I should suggest that the conditions of the uphill work of a minority—in this country at least—are too exacting to be continued; that the results we obtain are not so very much better than those obtained by our opponents' methods, tinctured as they are by the modifications our immediate predecessors,

following Hahnemann, have grafted on their practice, and that nothing remains for us but some submissive form of compromise, you would ask me to vacate the chair to which you have just called me.

You would point to these walls laden with witnesses to a faith worthy of all credence, to results which have been achieved through their steadfastness, and bid me look forward to a time when our master shall come to his own, and the command "let likes be treated by likes" take its place, not perhaps as the sole rule, but as one of the most important of the guides to the healer.

If I were to draw attention to the comparative paucity of our numbers you would say, imitating the spirited words of England's warrior king, that if we must ultimately fail, we have more comrades than enough to fail with us; but that if we are to succeed the greater glory—rather should I say satisfaction—to the few.

Still, if as we all—including the one who now addresses you—believe, that our system must eventually take its rightful place in the great art to which we devote our lives, we must renew our vows to each other, and work while it is yet day for the night cometh.

THE PROVINCE OF HOMŒOPATHY IN MEDICINE.¹

BY PETER PROCTOR, M.R.C.S.ENG., L.R.C.P.EDIN., L.S.A.,
President of the Liverpool Branch, British Homœopathic Society.

GENTLEMEN,—At this opening meeting of a new session of our Society I have in the first place to thank you for your kindness in electing me to the chair, and in the second place I would express the hope that the session will be fruitful in good discussion, so that at its close we may feel that something, however little, has been done to advance the study of perhaps the most difficult of all professions, that of

¹ The Presidential Address at the Liverpool Branch, delivered October 12, 1905.

medicine, and especially that department of it we are here to practise and cultivate.

A considerable time has elapsed since I had the opportunity of addressing you in any official capacity, and I am glad of the privilege of saying a few words now regarding our relation to medicine in general.

We find ourselves at the end of a hundred years of controversy, of much eloquent speech and writing, of private and public demonstration of our system, still a small minority in a large professional body. We are in the anomalous position of being neither accepted nor refuted, which is certainly not logical on the part of our opponents, for we ought to be either one or the other. The anomaly is increased by the fact that the allopathic treatment is largely permeated by homœopathy, and we ourselves have frequently to resort to antipathic means for temporary help, so that one would think a mutual recognition of each other's merits would be the most natural thing in the world. Much of the bitterness has gone out of the controversy, and some amount of mutual toleration has come about, for, be it remembered, the intolerance has not been all on one side, a fact we are very apt to forget when discussing these matters amongst ourselves. But however much the two methods of treatment may be intermixed, and howsoever each may be tolerated by the other side, there is at the root of the matter a radical difference that must effectually prevent any possibility of compromise. The homœopathic and the antipathic methods are so essentially dissimilar that one or the other must be adopted. We know of no *via media*, and until some eirenicon is thrown out that will enable us to see the good points on both sides, we shall remain in the absurd and anomalous position of both sides repudiating in principle what they adopt in practice, in very different proportions, I admit. That such an eirenicon is possible I firmly believe, and in this conviction I have brought together a few illustrations with the intention of showing that, while homœopathy has its supreme place within its own province, it does not cover the whole domain of medicine, and that outside its special province it must yield to other laws. My attempt

is but an outline in character, and is to be regarded as merely a suggestion in the direction indicated. Your own experience in daily practice will help to fill in the picture.

We all know that from Hippocrates downwards medicine has recognised the principle of similars as well as that of opposites, and I have already had occasion to point out that in the "Organon" Hahnemann repudiated the notion of claiming any originality for his doctrine, and it is no compliment to his scholarship that he should be supposed to have been ignorant of the fact and to have discovered it for the first time. His merit, like that of Darwin in regard to evolution, is not that he discovered it, but that he proved it and made the law of similars the dominant law of treatment. When, however, Hahnemann threw the whole weight of his genius into the homœopathic scale, by a natural reaction the other side balanced it by a corresponding movement on the opposite scale, and now we see, as just said, that, although we each employ both sets of remedies, we have nailed different flags to the mast, and have fought under them for the last hundred years, and, if this irreconcilable attitude continues, we shall continue to fight on apparently to all eternity.

Now, it is quite possible to treat disease throughout on homœopathic lines, and some of our purists insist on doing so, refusing to avail themselves of any resources outside the *materia medica pura*, but the question we have to ask ourselves is this, do we in such case give our patients all the help that medicine can afford, and, if not, what conditions call for auxiliaries?

We who are convinced of the general superiority of homœopathy need not be afraid to look around us and look facts in the face. In doing so we shall see that allopathy in these days is not the tissue of baseless theories concerning medicine and disease that Hahnemann rightly denounced, as is admitted by the allopaths themselves; it is, on the contrary, a vast accumulation of facts, sifted by critical eyes, with very few principles indeed, for the modern physician has had such a surfeit of obsolete medical systems, that he has come to dread anything like a law of therapeutics. All

the same, however, he averts his gaze from anything that looks like homœopathy and seeks for help in the direction of the physiological action of contraries. Whatever liberality of thought he may profess, there is no question that the dominant law in the allopathic mind is that of cure by physiological opposites. Unconsciously he turns his face in this direction until, partly from habit and partly from prejudice, this idea has obtained complete possession of him, and the mere suspicion of the law of similars being a reality in any possible case is a thing to be explained away. We must avoid this attitude of mind ourselves, and frankly allow the law of contraries to exist and to be a true law, as is admitted by our late colleague, Dr. R. Hughes, and indeed, by all liberal-minded men on our side. It is also to be admitted that the world as well as the profession generally is so universally in its favour, that the law of similars has to fight against pre-conceptions and prejudice to a painful degree, and we win our way only as a swimmer does against the stream. It is for us to vindicate the homœopathic law, to make good its claims, and to show that in the safety, certainty, and permanence of its cures homœopathy outdistances its rival. But in order to do so let us endeavour to define its province, and not expect it to do what it is not competent to do, and what it does not profess to do.

At the outset, let us remember what homœopathy is. It is simply the correction of deranged vital action, and is in no way concerned with the causes of that derangement. Whatever means we may employ for attacking, those causes are outside its province. When we succeed in attacking and removing them as we sometimes can, we save an infinity of trouble, and it may be noticed that the achievements of modern medicine are almost exclusively in this direction. The destruction of organic germs and the neutralising of their products, the destruction of low forms of animal and vegetable parasites, the correcting of dietetic errors and the improvement of hygiene in general, have given a power to modern medicine that did not exist in Hahnemann's day.

It would almost seem that the future of medicine will be of the nature of preventive treatment, leaving the *vis medi-*

catrrix little or nothing to do. The numerous antitoxins are aimed at this direct causal cure, and are consequently outside of the homœopathic law. It is only the vaccines that trench upon it, for they are employed to evoke the vital reaction to provide its own antitoxins, and they thus come within the range of similia, or are even isopathic.

There are some forms of skin disease, such as tinea, that are contingent upon constitutional dyscrasiæ, in which homœopathic treatment is markedly helpful, but even here there seems to be no good reason why the external parasiticide should not be jointly used. It is in such case an auxiliary, not a rival. I have known some of our school who were disconcerted by the rise of this germicide treatment, but when we remember that in removing the cause of disease we are in no wise contravening the homœopathic law, which deals only with the morbid process itself, we may with a clear conscience employ all such resources that enable us to comply with the first law of medicine, *tolle causam*. An extension of this principle may, and, I think, ought to be, applied to the various products of metabolism that are retained in the system from imperfect excretion. These, it seems to me, constitute morbid causes that we have as much right to get rid of as if they were on the surface instead of being in the interior of the body. Depuration of the blood through the skin, liver, kidneys or bowels, may become of the first necessity in threatened uræmic convulsions, whilst at the same time we tackle the organs at fault with our specifics. We have used the Turkish bath for this purpose without scruple, and why we should not do the same with the other emunctories does not seem clear to me. Flushing the drains is often of the first importance. We send our patients to Harrogate or Carlsbad, where this process of depuration is carried out, but very often I fear we neglect to do the same at home. Remove the cause, whether it is primary or secondary, when it is of a nature that can be got at, and clear the way for the more efficient action of the homœopathic remedy.

So far, homœopathy, as Hahnemann defined it, stands outside of all those measures that endeavour to remove the causes of disease whether they are of a material or other

nature, and if it were possible to do this all along the line how simple would the art of medicine become! But we know this is not possible. Even with the knowledge that the morbid germ is doing its fell work in the system we cannot as a rule get at it directly, but must just help the system in its struggle against the foe. In other directions than bacterial infection, in the large field of disease due to plus or minus of the normal forces around us and to the inherited and acquired defects of the organism, we shall have quite enough to tax all the resources of our art after all our efforts at removing the primary causes. In this arena of the deranged vitality, *per se*, homœopathy and antipathy come into conflict at short range. The allopath is not without his array of facts just as we have ours, both indisputable, and it remains for the future to witness the result of the struggle for survival. It will be seen that the homœopath points to his successes in acute disease for the most part, whilst the allopath points to his tonics, stimulants, purgatives, diuretics, &c., adapted to conditions of torpor and exhaustion of the various organs, and it strikes me that we have here the key to the strong positions on both sides. The allopath will take our acon., bell., arsen., ipec., antim., tart., merc. cor., for the purposes that we do, and on occasion we use his strychnia, strophanthus, digitalis, ferrum, cascara, secale, &c., in states of inertia. It is but rarely we have any necessity to resort to his pharmacopœia in acute disease. In states of inertia such as uterine hæmorrhage *post partum*, in fæcal impaction, in syncope, in short, in any severe organic failure, where relief must be immediate, there is no alternative to the giving of the special physiological stimulant. This rule applies often in cases of aged patients in whom the vital reaction is feeble, and can hardly at times be elicited at all. We have in such cases to fall back upon stimuli "whose entire physiological action is *not* absorbed in their therapeutical," but whose physiological action is very much wanted.

There is another class of cases in which we unhesitatingly employ antipathic means. I refer to cases of medicinal disease called poisoning. If we were called to treat a case

of opium poisoning, after doing our best to eject the drug we should resort to tea, coffee, belladonna, perhaps, and artificial stimuli to the skin. In a case of strychnia poisoning we should employ chloral most probably. With prussic acid, ammonia would be employed. In nicotine poisoning we should not give tea, its nearest analogue, but alcohol. In short, we do as a matter of fact depend in such cases upon the antagonistic remedy and not upon the similar, and why we should do so does not seem clear to me, knowing as we do the power of the similar in diseases of an ordinary nature, and that own an equally definite origin to specific infection. Facts like these have to be recognised, and if possible co-ordinated with our homœopathic law. One may just mention the fact of palliation by morphia, chloral and other pain killers in the later stages of cancer, in the passage of calculi, and in a few other instances. These all show that we do practically recognise the necessity of treatment by antagonism in a certain number of cases. I am not advocating any new mode of treatment, but merely pointing out as a matter of fact what we do without hesitation under the circumstances. These do not constitute all the measures that are outside the law of similars, but they are enough to justify the thesis that homœopathy has its province, and there are resources outside that we are compelled to fall back upon at times. The province is somewhat indefinite, and it is our duty to explore it as far as practicable in every direction so as to learn what are its real boundaries. The cause of homœopathy has suffered from undue disparagement by the other school, but it has also suffered by exclusive claims amongst ourselves. Pre-eminent as we hold it to be in the broad field of practice, we have to remember it is only one law of medicine, and there are other laws that are competing with it, and if some of these laws are outside the range of our own they must be fairly recognised, and if possible assigned their relative spheres of activity. For my own part I am satisfied we have nothing to fear in so doing, and I am firmly of opinion that, as a result of the struggle for existence amongst remedial agents, when the roll is called in the distant future our acon., bell.,

bry., arsen., puls., and a host of others, will be amongst the survivors to answer to their names. The law of *similia similibus curentur* is perhaps the most comprehensive that was ever proposed in the whole history of medicine, and it is amazing to see the extent of its usefulness; but that it covers the whole ground is obviously not true. We have for a long period been testing its capacities in every direction, and rightly so, but now I venture to submit some attempt should be made to define its limits. We know the efforts that have been made to explain the homœopathic cure. It has been a problem from the beginning. At present the opposite action of the large and the small dose finds most favour, so that, as Dr. H. Nankivell said in his presidential address before the London Homœopathic Society the year before last, "The doctrine of similars is the only method whereby the practice of contraries can be faithfully and scientifically developed." This matter cannot be argued now, it is too large a subject to be dealt with at the end of a paper, but I would just say that, although that explanation fits in with some instances, it does not appear to do so with all. When we get to explaining homœopathy on the principle of contraries we are on the high road to allopathy with its contraries as expressed in oppositely acting drugs. For my own part I am rather disposed to regard the homœopathic cure as being in some degree analogous to the rudder of a ship that guides it and corrects its deviations but does not supply the driving force, that belongs to the wind that fills the sails. Whenever, then, we use the driving force in treatment, and we often do, I venture to think we are not using homœopathy. Some instances have been already adduced of the employment of this driving force, and, if I may repeat, whenever that occurs it is outside the province of homœopathy. I would venture to suggest that one cause of our difficulty in explaining the *modus operandi* of the homœopathic cure lies in the fact of the infinite variety of disease, and the actually opposite conditions of the one disease according to its different stages. Acute disease may begin with great vital activity and end in exhaustion, and it is conceivable

that in the early stage we may see only the purely and truly homœopathic action of the remedy on the wave-interference principle, but in the latter stage of exhaustion and in most passive conditions of debility we may apply the theory of stimulation. Indeed, in all the cases of purely minus quantity of vital action it is difficult to see how any remedy can act except as a stimulant. The obvious primary and secondary effects of drugs, and the different doses required in such conditions, rather lend support to the view. If this be the case we shall fail to make a single explanation fit the two cases, and it may turn out that the homœopathic cure requires a double explanation, inasmuch as a double curative action is called into play by the one medicine according to the stage of disease or to its nature from the beginning. For instance, the active symptoms of scarlatina may be regarded as under the control of belladonna acting on the principle of similarity, pure and simple, whilst the passive state of hæmorrhoids and varicosis generally would seem to be benefited only on the principle of eliciting tone by physiological stimulation:—

“Take thou some new injection to thine eye
And the rank poison of the old will die.”

This often-quoted passage may be quite true and fit a certain number of cases, but how if there be no poison, but only a state of vital depression from previous over action or from simple impairment of nutrition? To apply my illustration, the rudder is used in the one case, but the driving force of the wind in the other. However this may be, and I am not offering the illustration in any dogmatic manner, because we know how mysterious is the invisible mechanism of bioplasm, and in drawing analogies with vitality we know how imperfect they probably all are. The two points I would insist upon are, first, the possibility of the action of the homœopathic remedy not being the same in all cases, and, consequently, any one explanation of its *modus operandi* would be insufficient. The really homœopathic and the contrary actions may be both true, according to the active or passive states of the disease that may be under consideration. In the second place I would point out the obvious fact

that the mere universality of any law, whether of physic or physics, affords no guarantee of its self-sufficiency. Gravitation is probably a universal property of matter, but it is not the only force in the universe. So with homœopathy, true and universal as it may be, it yet has its range of action, and it is for us to determine its province in the domain of medicine.

ONOSMODIUM IN MUSCULAR ASTHENOPIA.¹

BY C. KNOX SHAW.

SOME years ago, when the late Dr. Hughes was at work upon the "Cyclopædia of Drug Pathogenesy," he drew my attention to the probable value of onosmodium in muscular asthenopia. Since then I have prescribed the drug frequently, and with marked benefit. But I have been much surprised to find to what a number the name and action of the drug is quite unknown. I have therefore ventured to bring a short notice of it before the members of the Society.

Onosmodium is a plant of the natural order *Boraginaceæ*, growing wild in America. According to Clarke's "Dictionary of Materia Medica," it is commonly known as "false gromwell," a tincture of which is made from the entire fresh plant, including the root.

It was first proved by Dr. W. E. Green, who published his results in the *Hahnemannian Monthly* in June, 1885.

He appears to have proved the drug three times upon himself and twice on Mrs. C.

The head and eye symptoms are marked and characteristic. I give them in the order of frequency of occurrence.

Dull occipito-frontal headache. Dull heavy pain in frontal regions and in both temples, also in mastoid region, the temporal headaches being most markedly left-sided. Headache over both eyes. Dull pain on the top of the eyeballs. Feeling of tension in the eyes. Wants to look at

¹ Presented to the Section of Surgery and Gynæcology, November 2, 1905.

things very far away. The eyes feel tired, as if they were stretched wide open. The eyes feel tired. The lids feel heavy.

The vision is blurred. During the proving visual acuity was reduced from $\frac{10}{8}$ to $\frac{8}{10}$, and remained so for several days, returning to $\frac{10}{8}$ when the drug was left off.

Ophthalmoscopically it was noted that the optic discs were hyperæmic and the retinal vessels engorged.

Associated with the head and eye symptoms there were certain other frequently recurring ones: numbness and weakness in the legs, tired, weary feeling in the limbs, weariness, very tired.

Another marked symptom is rawness and dryness of the throat. The drug is a sexual depressant in both the male and female, and in women excites uterine and ovarian pain, as well as aching and pain in the breasts.

When studying the drug one is struck with the marked association of the head and eye symptoms with those of great muscular tiredness and weariness, especially of the lower limbs.

The cases in which I have found the curative sphere to be most marked are those with dull, aching occipito-frontal headache, or left-sided headache, with heavy lids and tired, weary eyes, with inability to use them for any length of time, general lassitude and weariness, especially of the limbs, a feeling of tiredness all over.

We meet with this condition very frequently in cases of asthenopia, when the symptoms are out of all proportion to the amount of the error of refraction discovered.

I am convinced that it is not wise to ignore these small errors of refraction, and that it is necessary to correct them optically, especially in astigmatism, when the asthenopic symptoms are marked, so that I almost invariably give the patient a prescription for glasses, even when ordering the indicated remedy. As the prescribing of glasses in a great many cases is all that is needed, and all symptoms will disappear under their use, it not infrequently happens that no prescription for medicine is given unless the patient continues to complain at a subsequent visit. In many cases of errors

of refraction we have not only to correct the optical error, but to treat the temperament of the patient in whom we find the error, and it is in such cases that we find drugs like onosmodium so useful. Similar acting drugs are *actea*, *ruta*, *kalmia*, *gelsemium*.

Onosmodium has been used in all dilutions from the mother tincture to the cm. I have prescribed it most frequently in the 2x or 3x.

Dr. SPEIRS ALEXANDER said the paper appealed to him because just previous to coming to the meeting he had seen a lady who complained of exactly the symptoms described by Mr. Knox Shaw. She was the subject of myopia, which had been corrected, but in spite of that the patient informed him that she had not only the sensations in the back of the head and the tired feeling, but also sensations in the throat, in the limbs, and all over the body. He felt somewhat at a loss as to what medicine to prescribe for her, but if he had heard the paper before seeing the patient he should have had no hesitation in prescribing onosmodium, and he should do so eventually. Some years ago he prescribed onosmodium in several cases, but he presumably did not select the cases with sufficient care, as he had no recollection of its effect. Mr. Knox Shaw had defined the sphere of its action so accurately that practitioners might in future use it with greater confidence.

Dr. BYRES MOIR congratulated Mr. Knox Shaw on the type of paper he had brought before the Society. Nothing could be more useful to the members than a few similar short papers on special drugs, and he hoped they would be forthcoming during the present session.

Dr. STONHAM thought that *natrum muriaticum* should be added to the list of similarly acting drugs mentioned by Mr. Knox Shaw. It was very useful, not only for myopia but also for astigmatism, and often relieved the pain before glasses were used.

Dr. LAMBERT stated that he had used onosmodium occasionally, but more empirically than on particular symptoms. He had prescribed it for eye strain when he did not see indications for any other medicine. As Dr. Stonham had remarked, he thought *natrum* was useful in a great many cases of eye strain. He had had some very marked results with *natrum*, where the drug had acted without the correction of the error, even when there had been a large amount of astigmatism; it had relieved all

symptoms of eye strain before the patients had their glasses. He mentioned the case of a soldier's wife, who had a high degree of myopia, something like six or eight diopters, with about a couple of diopters of astigmatism. Some years ago he had ordered her a full correction. Two or three years afterwards she complained of very definite symptoms of eye strain, and he first concluded that he had made a mistake by ordering a full correction. He found, however, that there were definite reasons for doing so, because the patient not only obtained very excellent distant vision, but could read perfectly well with the glasses. Before altering the glasses, as the myopia had not increased, he ordered natrum for a month, which entirely relieved all the symptoms, and the patient had not been to see him since.

Dr. HAWKES (in the chair) stated that natrum muriaticum had been his favourite remedy in such cases. As a matter of personal interest, he would like to ask Dr. Stonham and Dr. Lambert in what dilution they had used the drug.

Dr. STONHAM and Dr. LAMBERT replied that they had used it in the thirtieth dilution.

Mr. KNOX SHAW, in reply, said he wrote the paper with a very definite object. It had been so often said that from the surgical section no therapeutical work was ever presented. It had been his desire to write a short paper which would convey a certain amount of information, which he trusted would be valuable, and to set an example which might be followed by others. It was a complete omission on his part not to have added natrum muriaticum as one of the remedies for asthenopia, because he had found it of extreme value, and had found it helpful even in such a material dose as 6x. He had used it occasionally in the thirtieth dilution. He had used lillium, but it had never been a drug that had "caught on" with him. He had used it in cases where he thought the astigmatism was due to ciliary muscle spasm, and now and then he had obtained benefit from its use. He would give actea where asthenopia was associated with some pelvic disturbance. It was extraordinary what a number of people with a pelvic disturbance had muscular asthenopia, and in such cases he prescribed actea or macrotin.

TWO CASES OF CEREBRAL TRAUMATISM.¹

BY W. CLOWES PRITCHARD, B.A., M.R.C.S., L.R.C.P.,
Surgeon to the Buchanan Hospital, St. Leonards-on-Sea.

MR. PRESIDENT, GENTLEMEN,—Although the title of my short paper is “Notes on Two Cases of Cerebral Traumatism” I really cannot be sure that it is correct, for the second case that I shall give you presently has quite puzzled me, and there is a history of “head symptoms” prior to the injury that will be described.

The first case is that of A. H., lad, aged 14, a member of the Church Lads’ Brigade. On November 19, 1903, he was with several other members of the Brigade engaged in practising firing with small saloon rifles at their barracks. At the time of the accident he was marking for the rest of the team, when one of the lads accidentally let off his saloon rifle. The bullet, which was a little larger than a buck shot and somewhat elongated, entered the lad’s right orbit at the lower and outer part; this produced the sensation of a sharp sting, which was soon followed by smarting. Patient was taken to see a surgeon who advised him to go to the hospital. Instead of doing so, however, he walked home with the assistance of the drill master. He had about half a mile to walk, and whilst on his way home the eyelids began to swell, his head kept coming over “muddly,” and he was very sick. As the sickness continued on and off during the whole of the night he was brought to the Buchanan Hospital and admitted as an in-patient at nine o’clock the next morning.

Condition on admission.—Patient, a well-grown lad of 14, is distinctly showing signs of collapse, is very pale and still vomiting. There is considerable œdema and blackening of the right eyelids, and œdema of conjunctiva—the lids being almost closed and the œdematous conjunctiva showing between them.

The pulse is soft and somewhat thready, and numbers sixty-eight per minute. Patient complains of feeling weak and faint and of a “muddly” sensation all over the head, which is made worse if he attempts to stoop. On examining the right lower lid there is a small puncture to be made out, below and internal

¹ Presented to the Section of Surgery and Gynæcology, November 2, 1905.

to the external canthus; no other mark to be found. Careful palpation does not disclose any foreign body.

Patient can walk unaided, though it makes him feel giddy and sick.

As no trace of the bullet can be found, patient is put to bed between blankets, a hot water bottle placed to his feet, a hot boracic compress applied to the eye, and is given arnica 3c. \mathfrak{m} iii. every four hours.

The next day, November 20, temperature rose to 100° , patient feeling slightly easier. On November 21 temperature 101° , November 22 temperature 101.8° , very free action of skin, bowels opened by glycerine enema; patient feeling greatly distressed.

On November 23 temperature began to drop gradually and reached 99° . Patient feeling much more comfortable, although head still "muddly."

After November 28 the temperature kept below 100° , and on December 11 patient was allowed to get up.

During this period there was no sickness, and no localising symptoms whatever, in fact, patient seemed quite well excepting for the continuance of the "muddly" feeling all over the head, not more marked in one place than another.

I now got Mr. Chaplin, of St. Leonard's, to take another X-ray photograph. I omitted to say one had been previously taken when the lad was very ill, and it had not been a success. This time the photographs were excellent, and by taking two, one laterally and one antero-posteriorly, the bullet was localised in the right occipital lobe about $\frac{3}{4}$ in. from the middle line, and from $\frac{3}{4}$ to 1 in. from the surface. The photographs, which are very clear, show the position of the bullet.

I decided to operate, and on January 15 patient was put under A.C.E., a horseshoe-shaped incision was made, the skull trephined, the dura mater opened, and after some little time the bullet was found and easily removed.

The dura mater was then stitched up, the portion of bone replaced, and the wound stitched and sealed with R. benzoini co, and patient put back to bed. He made an uninterrupted recovery, with the exception of a superficial stitch abscess, which was soon got rid of.

I have frequently seen the lad since, and he appears to be perfectly well. The portion of bone replaced was re-vivified, and altogether he did splendidly.

There is just one thing I ought to mention: the vision

of the left eye is $\frac{5}{8}$, whereas that of the right eye is only $\frac{6}{18}$, and cannot be improved by glasses, nor can I detect anything wrong with the fundus of the eye or the optic nerve.

From the photographs can be traced the course of the bullet, and no doubt it would not be difficult to inform ourselves of the various structures injured by it. From its course, backwards and inwards, it seems to me as though it must almost have grazed the eyeball.

This is a case that no operative treatment could have been attempted but for the X-rays, as absolutely no localising symptoms appeared, the sole symptom being the persistent "muddy" feeling all over the head.

The next case I wish to bring before you is very different, and by no means so satisfactory. I was not able to make a diagnosis, and the patient lost his life; moreover, the lad's parents were so bitterly opposed to any *post-mortem* examination that the only means of clearing up the case were denied.

C. F., aged 17, a well-grown, bright, intelligent and intellectual lad—a school teacher by profession—came to my out-patients at the Buchanan Hospital at the end of October, 1904. He had been playing football on the Saturday previous to the Tuesday on which I first saw him, and had been charged and knocked down. Whilst on the ground he had been kicked upon the left frontal eminence, causing the right side of the head to come into forcible contact with the ground. (The ground was not frozen, and patient did not remember striking his head on a stone.)

He complained of a small superficial wound over the left parietal eminence, of some swelling of that part, and of some headache. The wound appeared to be insignificant, and there was not much swelling or bruising. The headache did not seem to be severe, and he was given arnica internally. I saw him once more on the following Tuesday, when the wound was healed and the swelling had disappeared, but there was still some slight discolouration over the frontal eminence. He was told to go on with the arnica.

I did not see him again at the out-patient department, and thought he was all right. Fifteen weeks after I was called to see him at his home. He was in bed, and had been for some weeks. The doctor in attendance was treating him—so I was informed—for a very bad attack of indigestion.

I noticed a great change in the lad's appearance—he had lost flesh, and the cheeks were considerably paler and the eyes somewhat sunken. Mentally he seemed quite bright and clear.

I was told he had been "bringing up" everything he took, even a little water could not be retained for long. The vomiting was quite easy, and without any apparent effort, and would come on irregularly. Sometimes he would have very frequent attacks, and then for a day or two would scarcely have any. He stated he could not see so well as he had done; that he had had several attacks of a curious nature (evidently aphasic), so that he could scarcely speak; that he had had twitchings in both arms and legs, and that there was some loss of power; these attacks were more marked on the left side. On examination he had double optic neuritis, more intense on the right side; slight paralysis of the left side of the face; no appreciable difference between the power of the hand grips, no paralysis of arms or legs, and had complete control over the sphincters.

I may say that at the time of the accident there was no loss of consciousness, no sickness, no bleeding from nose or ears.

I kept the patient in bed, gave him a light diet, and watched him for about three weeks, and then, as he did not seem to get any better, he was admitted into the Buchanan Hospital.

From February 16 to March 13 his condition seemed to improve slightly, but he had frequent attacks of severe headache, mostly on the right side. During these attacks patient got very low, could not bear light and noise, vomited almost incessantly, became aphasic, and had muscular twitchings of face, arms and legs. These attacks would last for a day or two, and then patient would get fairly comfortable again—could talk quite plainly, would scarcely vomit, and the headache would get much better.

I wrote Dr. Goldsbrough about the case on March 5, 1905, and in reply to a letter from him I sent him the following account of the case:—

(1) *As regards speech.*—Patient is *very* quick in response to questions. He has word and sentence co-ordination perfect except when he has one of his bad turns—about once a week—when he vomits frequently without effort, when the facial paralysis is more marked, when the headache is *most* severe, and at these times there is blurring of words, and occasionally one cannot understand what he says. Then the speech gets quite distinct again, and the vomiting and headache are much better. During the "better" periods patient understands everything—

in fact the brain seems very clear and very alert. He can also say, read, or write anything. A specimen of his writing from dictation is quite normal. During a "bad" time he knows what he wants to say, but cannot make himself understood.

(2) *Vision*.—There is no mind blindness. The movements of the eyelids are somewhat slow and jerky, especially of the left ones; he cannot quite close the left eyelids. Pupils are equal, are not dilated or contracted, and respond to light and accommodation, although perhaps a little tardily. Field of vision somewhat contracted on nasal side. He can distinguish colours.

(3) *Hearing*.—Acuity good. He hears better through meatus than by bony conduction. Neither tinnitus nor vertigo.

(4) *Taste and smell*.—Normal.

(5) *Tactile and general sensibility*.—Good.

(6) Occasionally there are twitchings of muscles of face. During a "bad" time there is loss of power in left arm and leg, but ordinarily this is not noticeable. The twitchings are slight—never amounting to spasms.

(7) *Knee-jerks* absent.—Thought I got slight ankle clonus of right foot once.

(8) *Sphincters*.—Patient has complete control over.

(9) *Temperature* 97° to 98·4°.

(10) Once had unconsciousness for a short time during a bad turn. No delirium.

On *March 18* a consultation was held, there being present Dr. Goldsbrough, Messrs. Knox and Frank Shaw, Mr. E. D. Shirtliff and myself.

After a thorough examination of the lad, Dr. Goldsbrough advised no operation, as there was not sufficient evidence of localisation of the mischief. I may say Dr. Goldsbrough noted that the lad had nystagmus, a symptom that had not previously been observed, although frequent examinations had been made.

The lad had been taking bell. and bry. since February 16, and was now put on bell. and arnica.

From *March 18* to *May 9* patient was under observation in the hospital, and gradually got worse. The optic neuritis became more intense, and then atrophy supervened, so that at the beginning of *May* patient became blind. The attacks of sickness increased in severity and in frequency, the facial paralysis became more marked, and the muscular twitchings lasted throughout. The mental condition remained practically the same, the most noticeable feature being the lad's alertness to sounds and prompt manner in which he would answer any questions. Towards the

end of this period patient occasionally lost control of the sphincters, both urine and fæces being passed unconsciously.

As the lad's parents were now anxious to have him home again, he was discharged from the hospital on May 9.

A fortnight after going home patient became suddenly deaf, and he arranged a certain code for replies to questions he asked, showing that his mind was still alert and active.

The downward tendency, however, still continued, and patient began to lose flesh rapidly, so that by the end of June he was practically a living skeleton. The mental condition at this time was greatly impaired, and patient could not be made to understand at all.

Nourishment was administered by means of a teaspoon; everything was passed in the bed, and patient gradually sank until his death, which took place on August 5.

A fortnight before his decease he developed Cheyne-Stokes breathing, and many times he seemed as though he were dying. Once during this period he became acutely delirious, screaming very loudly and trying to bite and tear everything within his reach.

Just a word as to his history prior to the injury. From quite a young lad he was often down with very severe headaches and pains in the head, some of these pains being similar to those he suffered from whilst in the hospital. During these attacks he would frequently vomit, and, as far as the parents could remember, the food came up without apparent effort.

Dr. A. E. HAWKES (in the chair) congratulated Mr. Pritchard upon the success that attended the treatment of the first case, and more or less commiserated with him on the fatal termination of the second. All would agree that the first case did not present the extreme difficulty of the second. At the same time, he congratulated him on the acumen he showed in treating the second case.

Dr. GOLDSBROUGH enquired whether, in the second case, the patient was a right-handed man.

Mr. CLOWES PRITCHARD replied in the affirmative.

Dr. GOLDSBROUGH remarked that he had the opportunity of seeing the second case. In a consideration of this case the chief point which presented itself was as to the localisation of

any pathological lesion. He could not come to any conclusion that the cortex was affected in any way, but he thought probably that there was some pressure on the internal capsule on the right side, although that was not consistent with the ordinary localisations of the speech centre, which was on the left side. Of course there were certain cases where the speech centre was localised on the right side, but it would be impossible for one to infer that unless the other symptoms were sufficiently definite to localise the lesion in the neighbourhood of the second or third frontal convolution on the right side. As the patient had spasmodic attacks of aphasia, and yet the weakness, which was not very definite, was on the left side of the body, one could not localise anything on the cortex on the right side, but regarded the paralysis as being a symptom radiated from a lesion deeper down in the substance of the brain. Another point bearing on that was that the patient had no convulsions, although he had alterations in consciousness, which indicated that the whole brain was affected in some way. The probability was that if there was any pressure on the convolutions there would have been convulsions. There might have been an abscess present deep down in the neighbourhood of the corpus callosum, lateral ventricle, or corpus striatum on the right side, towards the base of the brain, or else a localised meningitis resulting from a clot or an original hæmorrhage. It was rather remarkable that the serious symptoms came on fifteen weeks after the first injury had been seen, and that would favour the occurrence of meningitis or an abscess. That suggestion was also confirmed by the later symptoms, such as deafness and the nystagmus, which he noticed on the day of his visit. With regard to the first case, he would like to enquire whether Mr. Pritchard had tested the field of vision of the boy since he recovered, because it would be an interesting point to find out to what extent the field of vision was affected, and whether he had recovered it. He presumed the bullet was found in the occipital lobe itself, in the brain structure.

Mr. PRITCHARD replied that that was so; it was found three-quarters of an inch below the surface.

Dr. GOLDSBROUGH, continuing, said it was a most important point to find out whether the brain had recovered from such an injury. If the field of vision remained affected or not, this was a valuable point for physiological record. The boy's reference to a "muddly" feeling in his brain was of considerable interest. The expression was very indefinite, but it might be taken as

meaning two things—first of all, some defect in memory ; and, secondly, some accompanying sensation in the head referred from the part of the brain which gave bodily sensation, coupled with some loss of memory. If they were correct in localising consciousness in the whole cortex of the brain, that would account for the sensation the boy had, particularly as near the occipital lobes was localised also the somæsthetic sensation—*i.e.*, the sensation of the body itself. He would like to enquire whether the boy complained at the present time of anything in the nature of confusion in his memory, and did he complain of any relic or remains of the sensation that he complained of then—*i.e.*, the “muddly” feeling. The cases mentioned were very interesting from the point of view of localisation. Much had to be learnt from negative evidence as well as positive. He did not think enough had been made in the past of negative evidence in localisation—*i.e.*, if a patient had no symptoms indicating troubles in a particular area, that in itself was evidence that the lesion must be somewhere else, and in that way every case taught them something.

Mr. DUDLEY WRIGHT suggested that in the second case the lesion was possibly independent of the injury received, and judging from the occurrence of crossed paralysis it might be in the pons or cerebellum, and was probably tumour.

Mr. PRITCHARD, having to leave the meeting early, replied to the discussion so far, and said that the second case was a puzzle to him, and even now he was afraid he must consider it a little longer after Mr. Dudley Wright’s explanation. He did not quite understand the crossing of the paralysis, and why the right side was not so much affected as the left.

Dr. GOLDSBROUGH thought that Mr. Dudley Wright’s suggestion was a valuable one. When he saw the patient he tried to get the boy on to his legs, but he instantly turned very giddy, which would suggest some confirmation of the cerebellar tumour theory, although the symptoms, to his mind, did not point to the cerebellum.

Dr. SPEIRS ALEXANDER remarked, that by the narration of Mr. Pritchard’s second case he was reminded of a cerebral case which he reported in the Review a few years ago. In his case he thought all the symptoms which Mr. Pritchard described were present save one, namely, deafness. He (Dr. Alexander) diagnosed a cerebral tumour, and subsequently, having the advantage of performing a *post-mortem* examination, found a glioma just behind the left lateral ventricle. Taking that case into considera-

tion, he was rather inclined to agree with Mr. Dudley Wright, that there was a probability that a tumour existed in the brain prior to the accident, and that the latter was the starting point of activity in the tumour, leading to the subsequent history.

A GLIMPSE AT HOMŒOPATHY IN VIENNA.¹

BY C. GRANVILLE HEY, M.B., C.M. EDIN.

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MR. PRESIDENT and GENTLEMEN,—As most of you are aware, I was the fortunate recipient, in the early part of this year, of the “Travelling Scholarship” of the Ladies’ Committee of the British Homœopathic Association. The Association appointed Vienna as my centre of study, and among other instructions furnished to me ere my departure was the following: “The travelling scholar will be expected also to attend regularly the practicable clinics at the Homœopathic Hospitals in Vienna.”

As soon as possible, therefore, after my arrival in Vienna I began to make enquiries about homœopathy and homœopathic hospitals, and was duly informed by the proprietress of the “Pension Vienna,” where I lived—herself the widow and mother of an allopathic husband and son respectively—that no one believed in homœopathy now; it was exploded and gone. I informed her that there still existed in Vienna at least two homœopathic hospitals, but she knew nothing of them. However (and here my thanks are due to Dr. Blackley), I had the addresses of two homœopaths whom I endeavoured to find out. I first found Dr. Franz Weinke, but as my German was so bad and he did not know any English (though I am told his mother was an Englishwoman) the interview was embarrassing to both and I was glad when it came to an end, which it did not do until I had succeeded in making him understand I wanted his hospital address and hours, also Dr. Klauber’s address.

¹ Presented to the Section of Surgery and Gynæcology, November 2, 1905.

These I obtained from him, along with the information that Dr. Klauber spoke English fluently. This rejoiced me; so the following Sunday I called at Dr. Klauber's address only to find the doctor was not at home, and to be informed that, as I was a doctor and wished to see him as a visitor, the best place to see him was at the Lebenswarth'sches Homöopatik Kinderspital, Liniengasse 19, from 10-11 a.m. On studying a map of the city I found that the two homœopathic hospitals were almost adjoining and that Dr. Weinke lived in the block of tenements which separated them. Moreover, I saw that I could not possibly reach either of them from my lodging near the Allgemeines Krankenhaus in less than twenty-five to thirty minutes by electric car.

Some little time later I called at the Homœopathic Hospital for Children, and after some preliminary explanations was permitted to pass within the massive and locked wooden doors which guard the entrance of this as of other hospitals in Vienna. A few minutes later a gentleman entered the room where I was waiting (which happened to be the room in which the Vienna homœopaths hold their Medical Society meetings) and introduced himself as Dr. Klauber. I presented my credentials and told him the object of my visit and the probable length of my stay. He then showed me rapidly through the children's hospital, pointing out the more interesting cases, and begged me to come back another time after the beginning of June, as he was very busy just then, but expected to have more leisure to converse with me and show me more of the cases and of the hospitals later.

Towards the end of June and in July we met frequently, and it was then that I was enabled to get what little information I have gathered regarding homœopathy in Vienna of late years. Perhaps it may not be out of place here first to give you a general outline of the introduction of homœopathy in Vienna, and some account of its doings there in its early years. With this end in view, I think I cannot do better than read you a short paper by the then prime mover in homœopathy in Vienna; it is entitled:—

“A Contribution to the History of Homœopathy” (de-

livered by Dr. Fleischmann in the meeting of the Centralverein in Vienna, August 10, 1855).

"Gentlemen,—I take the liberty to ask for your attention for a few moments. I do not want to talk in big phrases and roundabout words, nor do I want to put before you hypotheses and learned investigations; I even consider it out of place here, as time is so short, to put learned things before you, but I want to reply to one question which must come to every one of you to-night. Gentlemen, you have come here for the first time to a meeting of the Central Society in Vienna, and you will ask how homœopathy stands in Vienna, and what has been done for it here? It is just the reply to this question about which I want to speak partly to-night. I say partly, because as I am not representing Vienna (and I am not so indiscreet as to wish to represent it), and as in Vienna much has been done for homœopathy to which I have not given the helping hand, it will only be the Hospital of the Sisters of Mercy in Gumpendorf and myself about which I shall speak.

"In 1831 the late Count Coudenhove, Dean of St. Stephen's, took the noble resolution to bring the Order of the Sisters of Mercy to Vienna in order that the poor and sick inhabitants might benefit by their good care and nursing. This noble resolution found so much sympathy that, through many gifts from all classes of society, especially from the highest court and from the noblemen, the hospital could be erected, equipped and opened, and already in July, 1832, the cholera sick could be brought there. Dr. Mayerdorfer was appointed doctor and treated the sick in the usual way. On the advice of the Count, however, he then tried secretly some homœopathic remedies. Secretly, because since the year 1818 treatment by homœopathy was prohibited by law to all the doctors in Austria, and it was not a small risk in those times for a mighty man who was standing at the head of the medical profession to treat by homœopathy in a public institution. But already through these trials the first light of homœopathy came into a public hospital. Such a mixed treatment lasted until July 1833, when Dr. Schmid, already a homœopath, took the hospital over. This gentleman treated by homœo-

pathy, but every patient had, just for the above-mentioned conditions, a bottle or box filled with allopathic remedies on his or her table, and a longer or shorter, simpler or more complex, prescription over his or her bed. Although now and then a patient on his own initiative would take a dose of the medicine standing beside him, the hospital was in fact a homœopathic one. In 1835 I took charge of the hospital. During the first fourteen days I followed the old customs, but I got quite disgusted with such procedure, which was contrary to my opinions and convictions, and I threw all this superfluous ballast overboard to come at last to a definite decision, but nothing happened. Now, in 1836, the cholera broke out. The hospital, in accordance with the instructions of the Government, had to be opened for cholera patients, and I was asked to take the treatment in hand. I with pleasure acted up to this request, but got at once from his Excellency Count Kolovrat, then Minister of the Interior, permission to treat publicly by homœopathy. Out of 732 patients 488 were cured, and 244 died. After the epidemic I made a special report on the course and way of my treatment, gave the same to the minister and requested him, at the same time, to abolish the interdict against homœopathy, which had generally been eluded; and shortly afterwards a special order by His Majesty allowed to every qualified doctor free treatment by homœopathy. So at once the fetters dropped, which the homœopathic doctors of Austria had felt in a disagreeable way during eighteen years. This success not only had a very good influence on the already practising doctors, but its influence was still greater because, after that date, several young doctors turned to the new doctrine and visited the hospital; but in this way my position became a much harder one. Besides many and frequent serious difficulties which I first had to overcome in order to get and to keep permission for young doctors to enter into a convent (because the hospital was within the walls of the convent of the Sisterhood.—*C. G. H.*), the most peculiar requests were put before me. Many people wanted to open through me a discussion against other dissentients, but as I was not attacked there was no reason for me, and I felt no inclina-

tion to attack, so much the more as I considered conquest on peaceful lines to be the most durable; and I procured just by this calm, non-provoking behaviour, at least the outward esteem for homœopathy. Others again wished, without the least preparatory knowledge, to become in three or four weeks perfect homœopaths in my hospital, but I regret to say I did not possess the power of a 'Nuremberg magic funnel,' and I could not satisfy these people. The most of them, however, wanted to consider me as a direct teacher, not because they found the question so easy, but because they could not solve it. However, I then had neither the right nor the time nor vocation to teach them. Moreover, gentlemen, one often hears talk about a chair for teaching; I think, however, that nobody has thought about the difficulties connected with the same, or at least certainly not tried it. To us no scholars are coming to whom one can lecture on anatomy, physiology, pathology and diagnosis. To us are coming doctors who have just the same knowledge as we have. Have we to lecture about pharmacology? Properly speaking, one cannot learn remedies by books or by lectures, but at the bedside! And how should one lecture about them? In the same way as you find them in books? No! As it is being done in modern times, *i.e.*, to divide them into blood, nerve, head, heart, and other remedies? Still more, no! In my opinion there is only one good way of teaching, and that is that with aid of all helping sciences one takes up as well as possible the disease picture, states the remedies to be used, chooses the right thing and states the reasons for the choice; and this is the method I followed for the greatest part.

"The number of my hearers increased so that owing to lack of room they had to be limited, and there is scarcely one country in Europe in which there is not one or more young doctors practising homœopathy, which they have learnt for the first time in my hospital, and learnt to esteem by results. On the other hand, I looked at other hospitals, and I succeeded by my recommendation and influence in getting homœopathy introduced into the hospitals in Linz, Kremsier and Steyer, and smart homœopathic doctors put at the head. Even the hospital for the erection of which

the doctors Watzte and Wurmb received money from the government could only be opened through my intervention, and in Jerusalem a homœopathic hospital is flourishing which has only come into existence through my influence. In this way my hospital, at the head of which I am staying, practically became a nursery school for homœopathic doctors, and a mother hospital for homœopathic branches.

“As to the patients who have been treated by me, I have to divide them into two classes, *i.e.*, into those who were treated as out-patients, and those who were intern. I wanted to bring homœopathy to the knowledge of the people, because theories belong to the learned world and practice to the people. For this purpose I introduced consultation hours during which poor patients got medical advice and remedies without paying. At the beginning only 10 to 12, and later on 40 to 50, came, and at the present moment you see nearly 200 patients come on an out-patient day, so that the number of patients treated up to the present exceeds 60,000. In this way I have got the experience that strict diet is not necessary, at least for chronic diseases, as is generally believed. The people are so poor that you cannot prescribe them any other way of living, nevertheless many nice cures have been obtained.

“In the hospital itself have been treated:—Cholera patients 1,202, cured 793, died 409. In this form of disease there remains to us homœopaths still many improvements to be made, especially in hospitals. I have tried and tried again every remedy which has been recommended, and tried, but I cannot find anything worth speaking about or distinguishing in any of them. In my experience veratrum still remains the best remedy; secale in cramps; and, to improve the urinary secretion, nux.

“With other diseases were admitted 17,313; cured 15,734; discharged uncured 447; died 1,087; remaining 45; therefore about 6 per cent. died, but it must be pointed out that amongst the 1,087 dead, there were 466 with totally incurable diseases. I do not want to annoy you with the enumeration of the various kinds of diseases, but only call your attention to a few important figures and the remedies used for the same.

"Erysipelas 514, cured 510, died from superadded gangrene 4. With this form of disease I never had to use any other remedy than belladonna or rhus.

"Diarrhœa of different kinds 323, cured 319, died 3, remaining 1. The remedies most frequently used were ipecac., acid phosph., pulsatilla, merc. sol., and veratrum.

"Ophthalmia of various kinds 130, cured 129, discharged uncured 1. There are no better remedies than hepar and sulphur for scrofulous ophthalmia.

"Arthritis 888, cured 877, died from superadded miliaria 7, remaining 4. The best remedies against these were bryonia, arnica, rhus, and sulphur. The worst pains were stopped by nothing so quickly as by cold fomentations.

"Tonsillitis or cynanche 920, cured 919, died from gangrene 1. Atropa and merc. sol. were always sufficient.

"Endocarditis 57, cured 56, died 1. Spigelia was the only remedy.

"Pneumonia 1,058, cured 1,004, died 48, remaining 6.

In my experience there is no better remedy than phosphorus, which works so well in this disease; this refers to both sexes in every age and stage of the disease.

"Gastric fever 1,181, cured 1,173, uncured 1, died 7.

"Rheumatic fever 1,417, cured 1,416, remaining 1.

"Nervous fever (typhus) 3,165, cured 2,779, uncured 3, died 368, remaining 15. After having tried several remedies I have come back to arsen., and have seen the best results from same. The nearest remedy to this is kreasot.

"Intermittent fever 1,066, cured 1,059, died 6, remaining 1. Mostly and with best result I have used ipecac. and nux; then follows arsenicum, quinine rubbed in, china and pulsatilla. In the dropsies which very often follow intermittent fever, and even in the most important stages, I have found aurum most excellent.

"In giving you this contribution to the history of homœopathy, gentlemen, I have not asked for praise, because I never did it; I also fear no criticism, because I know that I have done my best; but I have considered it my duty to put before you that which the hospital has accomplished, and the good service which the Sisters of Mercy have rendered to homœopathy."

From the foregoing you can form some idea of Fleischmann's thoroughness as a homœopath, his unobtrusive persistency in the struggle against the opposition of the allopaths and the ruling powers, his unshaken confidence in the truths of the therapeutic system which he both taught and practised, and practised with such excellent results that he succeeded by demonstrable results alone in getting rid of a tyrannical interdict which had fettered medical freedom for eighteen or nineteen years. He succeeded not merely in getting the interdict abolished by Government, but in getting the order abolishing the interdict written by the Emperor himself, which, according to Austrian law, means that no government can again interdict it. If it is again interdicted, it must be by an emperor and in his own handwriting.

Until then homœopathic medicines, when found, were burned on the public executing ground, but I do not know what was done to the possessors or users of them. Nevertheless, the medicines were used clandestinely during the existence of the interdict, as we have seen.

After this success Fleischmann obtained State recognition as a teacher, being appointed "privat dozent," but to what end I know not, seeing that the longed-for chair of homœopathy was never established in the University, nor was any degree in homœopathy given. However, principally as the result of his work, homœopathy flourished in Vienna to such an extent that, in the language of a Viennese doctor, the whole city was in the hands of the homœopaths in the 'fifties and 'sixties.

Fleischmann died in 1867, and with him seem to have departed the spirit and energy of aggressive homœopathy, so far as Austria is concerned. There has, however, been one notable addition to homœopathy in Vienna since his time, viz., a Dr. Taubes, in 1877 or 1878, gave 400,000 florins (*i.e.*, £33,333 6s. 8d.) and endowed the children's hospital, and from that fund Dr. Klauber, the present physician, receives 50 florins (£4 3s. 4d.) monthly.

From that time little seems to have been done to advance homœopathy in Vienna, so far as I could gather by conversing with Dr. Klauber. At the present time it is repre-

sented, firstly, by two hospitals, viz., the hospital of the Sisters of Mercy in Gumpendorfer Strasse (*i.e.*, the original hospital opened in 1832) and the "Lebenswarth'sches Homöopath Kinderspital," endowed by Dr. Taubes, and opened in 1878. The former contains fifty beds for adults, equally divided between males and females, and is under the care of Dr. Franz Weinke, who practically lives in the hospital buildings and receives from it an honorarium of 1,200 florins per annum. It also contains the pharmacy, which consists of two rooms; the first room on entering acts as the dispensing department, and contains the dispensing stock bottles, &c., while the second is lined with shelves carrying large macerating bottles, for it is here that their tinctures are prepared by the Sisters of Mercy attached to the hospital. The Kinderspital also contains fifty beds, and has in connection with it the hospital for the sick sisters, which contains forty beds. These two latter are under the charge of Dr. Ignaz Klauber, and from these conjointly he receives an honorarium similar to that enjoyed by his colleague, Dr. Weinke. There is also an out-patient department open at 3 p.m. on Tuesdays and Saturdays for children, under the charge of Dr. Riefler, who also assists Dr. Klauber in the Kinderspital.

In July, when I was able to visit the wards most frequently, all three hospitals were under the charge of Dr. Klauber. The children's wards during that month were almost empty, as, after an outbreak of summer diarrhoea, the children had been sent away to convalescent homes, the only cases remaining being several of scrofulous ophthalmia, with more or less generalised scrofula, and a few of phthisis. The adult wards were fairly well filled. Here, again, very many of the cases were of a tuberculous nature, chiefly advanced phthisis, but there were a few interesting cases. As there are two large sisterhoods in connection with the hospitals, the sisters' wards are usually fairly well filled, and here, Dr. Klauber told me, the most interesting cases were usually met with, but, unfortunately, much as he would have liked to take me into their wards, he could not, except by special permission either from the archbishop or the Pope.

Secondly, homœopathy in Vienna is represented by some thirty homœopathic doctors, in practice mainly, if not exclusively, as physicians. They have a medical society, but it, like our own, holds no meetings during the summer months, and as none of the doctors other than those already mentioned attend the homœopathic hospitals, I had no opportunity of making their acquaintance.

Asked why none of the others took any part in the hospitals' work, he (Dr. Klauber) replied, "They are all too busy to take any part in hospital work, but no matter how often you invite them out to a day's shooting they do not refuse." The fact of the matter is their interests are centred in themselves and not in the cause of homœopathy.

Asked if the conditions under which the hospitals exist (*i.e.*, directly under the control of the church) did not exert a retarding influence, he replied "Perhaps a little."

Two things stand out prominently when one compares homœopaths and allopaths in Vienna, viz., first, the extreme smallness of the homœopathic hospitals as compared with the great size of the allopathic. The three homœopathic hospitals together total 140 beds, whilst the Allgemeines Krankenhaus alone has 3,000 beds, to say nothing of the other comparatively large hospitals scattered about the city. Second, the entire want of specialists of any kind among the homœopaths with the extreme of specialisation among the allopaths. Only one homœopath there makes any attempt at specialising, and that is in obstetrics, but he is so strongly tinctured with Matteism that the other homœopaths cannot encourage him. There are no homœopathic surgeons or gynæcologists, &c., &c., so that, *e.g.*, if a homœopath's patient develops anything of a surgical nature the patient has to be handed over to the tender mercies of the allopaths for the time being. In connection with the homœopathic hospitals there is a wing for eye diseases and diseases of the nose and throat, but these, alas, are under allopathic professors.

However, with the object of rekindling the aggressive spirit of homœopathy in Vienna, Dr. Klauber informed me that he purposes making a special appeal this session to the

society, of which he is president. One thing is strongly in their favour—the majority of the homœopaths' patients there are among the highest and noblest in the land, so that they have abundant influence behind them to support them if only their energies could be directed into a proper channel. Unfortunately, the whole of such institutions (as hospitals, &c.) in Austria are so under the thumb of the State and Church that they can scarcely move without special permission.

In conclusion, I would like to say I believe this is the first attempt to get into touch with homœopathy in Vienna which has been made by British homœopaths for many years, and I am hopeful that the relationships thus established will not be altogether barren of happy results. Dr. Klauber has promised that if he possibly can he will pay us a visit here next year, but, as he is a very busy man, it will have to be during the slack summer months when the Viennese are among the mountains seeking the cool air and shade which are not to be found during June, July, and August in the vast plain which immediately surrounds Vienna and extends in unbroken flatness for scores of miles to the north-east, east, and south-east.

Dr. MACNISH enquired whether Dr. Hey saw how the out-patient department of the hospital was conducted?

Dr. HEY, in reply, said that he did not, because he had not the opportunity of being present. The out-patient department opened at three o'clock in the afternoon, and as the most important clinics in the Krankenhaus were being held about that time, it was impossible for him to get to the out-patient department. As an addition to his paper, he might say that Dr. Klauber told him he remembered the time when, every summer, numbers of British and American doctors visited the hospital at Vienna, but that he (Dr. Hey) was the first who had been there for several years. Dr. Klauber added that he would be very glad if any English homœopathist going over to Austria would show a brotherly spirit by going to see the hospital and the work done there.

Dr. BURFORD thought that if any criticism could be passed

upon the paper, it was that the members would have been glad to hear a little more of Dr. Hey and a little less of Dr. Fleischman. It was very creditable to Dr. Hey that he should have so conscientiously and whole-heartedly carried out his instructions, and unearthed what homœopathy there was in Vienna. What a falling off there was in that city could only be imagined when they read of the enthusiasm that animated the Viennese homœopaths in the early days. The Association might congratulate itself on having sent out Dr. Hey as a pioneer visitor, and it was very good of him to have given, in the name of British homœopaths, a general invitation to Dr. Klauber and the other physicians practising at Vienna to come over to London and make their acquaintance. He did not think, however, the acquaintance-making should be all on one side. If English homœopaths had not more frequently rubbed up against Viennese homœopaths, the fault was not entirely theirs, because the difficulty of access to the Viennese homœopathic institutions seemed to have been by no means inconsiderable.

Dr. A. E. HAWKES (in the chair), in thanking Dr. Hey for his paper, said he had been very much surprised at the cholera statistics that had been given; he thought the figures were very much better than those stated by Dr. Hey.

Dr. HEY, in reply, said that the cholera statistics were given by Fleischmann and were not startling until compared with the statistics given of cholera in the other hospitals. Then the Viennese people saw from his results, in that disease alone, that Fleischmann's method of treatment was superior to that in general vogue, and that they were stifling something which ought to be brought to light.

REVIEW.

Rôle de la Distension Cardiaque dans la Production de l'Angine de Poitrine. ("The Part Played by Cardiac Distension in the Production of Angina Pectoris.") Par J. P. TESSIER, Fils, M.D. (Paris, J. B. Baillière et Fils, 1905, pp. 92.)

THE author of this essay (who is the son of our esteemed colleague, Dr. J. P. Tessier, of Paris, and grandson of the illustrious Jean Paul Tessier, the founder of *L'Art Médical*), has been

the fortunate holder of the post, first of *externe* and then of *interne*, at the Lænnec Hospital, under Pierre Merklen, a recognised authority upon diseases of the heart in general, and upon *angina pectoris* in particular, and he appears to have made the fullest use of his unrivalled opportunities of study. Most of the clinical material employed in this essay is derived from the hospital records, and the cases are presented in a manner altogether admirable. The author's studies have led him to reject the old-fashioned definition of "true *angina pectoris* as being that from which the patient dies, the false that with which he lives," and he is evidently of opinion that many of the cases met with in practice are undoubtedly instances of true, but not necessarily fatal, "breast-pang." He defines true *angina pectoris* as being "the *angina* of effort, no matter what the nature of this may be, whether walking quickly, ascending stairs, walking against the wind, carrying a burden, painful digestion, or violent emotion, in a word, anything which augments the work of the heart; it is, therefore, a *cardiac angina*, one in which the painful irritation of the (*cardiac*) plexus has its origin in the heart itself," and sets himself to enquire what the state of the heart is which, under the influence of exertion, provokes this irritation, this suffering, in the *cardiac* extremities of the plexus.

The author admits that "*coronaritis*" is the *great cause* of *angina pectoris*, and is the lesion met with in the majority of the cases examined *post mortem*, adopting Potain's views as to the immediate cause of the attacks, viz., that of *cardiac anæmia*. "The heart, sufficiently irrigated for its normal function, in a moment of effort having more work to furnish, needs a larger blood supply, and, not being able to receive this by reason of the arterial stenosis, is seized with cramp, that is, with an attack of *angor*."

He is at once met with the fact, however, that true *angina pectoris*, terminating in death, is undoubtedly, though rarely, met with without the coronaries being involved, and is driven to the conclusion that in order to explain the identity of the phenomena in these cases there must be a common mechanism, the proximate cause must, in fact, be the same in both classes of cases. This cause the author thinks he has found in the transient dilatation of the heart, or rather the increase of intraventricular pressure acting upon the already resistant muscular wall, in a word, the distension of the myocardium.

The author admits that the idea is by no means new, for he cites Beau, Schott, Curschmann, and Lauder Brunton, showing

that a similar explanation has evidently presented itself to each of these writers. The last named compares the attacks of painful heart-spasm with the pain felt in an overloaded bladder, when, owing to spasm of the sphincter, the viscus contracts against a resistance which it is for the time unable to overcome, and violent pain results.

This thesis of "cardiac dilatation" the author elaborates with much painstaking industry, and proceeds to demonstrate that it alone is capable of explaining angina due to aortic insufficiency, attacks due to overstrained heart, to coronaritis, and to tobacco poisoning (between which last there is the closest resemblance). It also explains the angina occurring after influenza, diphtheria, septicæmia, rheumatism, &c. He lays special stress upon the frequent alternation of attacks of angina and of cardiac asthma, and shows that, in most of these, pulmonary œdema is present, giving a long series of cases lending support to his views.

From our point of view, the chapter upon therapeutics is, perhaps, the least satisfactory in the whole essay, but the reasons for this are not far to seek. The author merely gives us the schema of treatment as carried out in all Merklen's wards at the Lænnec Hospital, and which, so far as drugs are concerned, may be summed up in his own words, "*cardiac tonics*." In the matter of diet his recommendations deserve careful consideration. Milk he regards as the ideal food for patients with angina, both by reason of its ease of digestion and of its diuretic properties. Even with milk he would limit the quantity given at one time, preferring to give frequent small doses of milk and water so as to diminish as far as possible the mass of circulating liquid and consequent work imposed upon the heart. For the same reason he would curtail the quantity of salt permitted to cardiac patients, for salt demands water, and so increases the circulating medium.

We have much pleasure in commending Dr. Tessier's brochure as a piece of honest, painstaking work, but would venture to express a hope that in a few years' time he will furnish us with a second edition in which the therapeutic chapter will be much amplified and in which the law of "*similia*" will be allowed free play.—J. G. B.

SOCIETY NEWS.**INTERNATIONAL HOMŒOPATHIC CONGRESS.**

At the meeting of the Society in October, the President (Dr. A. E. Hawkes), Dr. Blackley, Dr. Madden, and Dr. E. A. Neatby, were elected to form a committee to co-operate with representatives from the British Homœopathic Congress, and the British Homœopathic Association, and the American Committee for the preparation of papers, and otherwise promoting the success of the International Homœopathic Congress to be held in Atlantic City, U.S.A., in September, 1906. All communications on the subject, having reference to the Society, should be addressed to Dr. E. A. Neatby.

NEW MEMBER.

At the meeting in November, Frederick William Hayes, M.B., Ch.B., Victoria, late of the London Homœopathic Hospital, and Dudgeon Scholar of the British Homœopathic Association, was elected a member of the Society.

SUMMARY OF PHARMACODYNAMICS AND THERAPEUTICS.

Extracted from Exchange and other Journals by the Editor, in collaboration with J. G. Blackley, M.B., and T. G. Stonham, M.D.

Actæa Racemosa in Tonsillitis.—Dr. C. B. Gilbert, of Washington, relates the following case :—

A lady, aged 28, tall, thin and dark, unmarried, has been subject to tonsillitis since childhood, and has had at least fifty attacks, all ending in suppuration. I was called to see her on August 17, 1905, and found her with inflammation of the right tonsil; the pain was sharp and sticking, and she was unable to open her mouth more than slightly. There was a peculiar accompaniment, viz., a severe pain from the seventh cervical vertebra up to the top of the head and to the back of the eyes; it was constant and had come on with the attack. On account of this symptom, actæa was given. Its administration was promptly followed by relief of the pain and swelling, and for the first time in her life the tonsil did not gather and break. (*American Physician*, October, 1905.)—T. G. S.

Adrenaline. *Effects upon Lungs and Kidneys.*—P. Jousset subjected two rabbits to slow poisoning by adrenaline administered *per os*, the daily dose varying from 2 to 5 milligrams. This was kept up in the two cases for five and six months respectively, when the animals were killed and an autopsy performed. The lesions were identical in both and were as follows :—

Lungs.—Lesions of acute bronchitis with cellular proliferation; desquamation of the large bronchi with red and white corpuscles in their interior. Intense congestion with numerous hæmorrhages in the septa and in the alveoli; in others desquamation, with some large, slightly pigmented cells and leucocytes. Slight endarteritis in certain arterioles. Thickening of interalveolar septa by proliferation of conjunctive tissue cells. There were numerous hepatised points consisting of blood cells, alveolar and swollen connective tissue cells, granular fibrin and leucocytes, in fact,

pneumonic foci in the initial stage. No aortic lesions were found in either animal. (*L'Art Medical*, November, 1905, p. 346.)—J. G. B.

Adrenaline in the Treatment of Addison's Disease.—Gulbenk, of Constantinople, publishes notes of two cases of Addison's disease successfully treated by adrenaline, mostly in 1 : 1000 solution. The first case was that of a man, aged 31, with tuberculous family history. The symptoms were typical and comprised extreme weakness, gastric pain and vomiting, absence of sugar in the urine, and bronzing of skin of face and extremities, and of the buccal mucosa. The pulse was 120, and the left apex was suspect. Treatment was commenced by giving the supra-renal gland of the ox either raw, grilled, or taken in small pieces in hot soup. Vomiting ceased within five days, and at the end of a fortnight the pains had almost completely disappeared, and strength was gradually returning. At the end of two months, the patient having put on flesh considerably, Gulbenk prescribed adrenaline 1 : 1000 in doses of 40 drops gradually increased to 60 drops daily. In twelve months from the time he was first seen, the patient felt quite well, could take long walks without fatigue, and the colouration of the skin had almost disappeared.

In the second case, that of a lady, aged 46, the symptoms were similar, but more pronounced; melanoderma, which constituted a great disfigurement for the patient, asthenia was extreme, and vomiting most intractable, whilst the pulse was 140 per minute. Treatment was commenced with the fresh glands, but as these were immediately rejected, adrenaline, administered *per rectum*, was substituted. At the end of a few days all vomiting had ceased, and the patient was able to resume the ingestion of the gland itself, with the result that in five weeks she was able to walk. At the end of six months (at the patient's request), adrenaline 1 : 1,000 was prescribed, and she continued to use it for nine months longer. Thinking herself entirely cured the patient abandoned the treatment, but within ten days had a relapse, pain, vomiting and asthenia reappearing after returning to the drug; however, she very soon found herself as well as before. (*L'Art Medical*, October, 1905, p. 315.)—J. G. B.

Arsenic. A Case of Poisoning.—Mrs. G. accidentally swallowed an unknown quantity of arsenic, probably less than 30 grains; she did not discover her mistake for an hour and a half, but fortunately the stomach was full. She now took mustard and water,

and egg albumen, which quickly caused emesis. She was seen by Dr. Bager three and a half hours after the occurrence. During the three succeeding days the following symptoms developed : Cutting over the eyes, in temples, above ears and in cheek bones ; this gradually passed into a dull, tired feeling, felt most in the facial bones ; then followed symptoms of a cold in the head, with a squeezing pain in the malar bones. The face was bloated and red ; she is normally very pale. Smell of the cooking nauseated her, and she vomited regularly every hour ; each attack was preceded by restlessness, and accompanied by a sense of heat all over. Not thirsty, but when ordered to drink hot water she thought cold would do as well ; but it did not seem to go down, but was regurgitated before reaching the stomach ; upon taking the hot water, however, all went better, but she could not take much at a time, there seemed no room for it. The stomach was full of gas which was forcibly eructated in quantities. Sharp ache across kidney region, > heat, with very scanty urine. Tongue looked rough, with a red spot near tip. Colchicum 200 was given as an antidote. (Dr. C. M. Bager in *The Chironian*, August, p. 47.)—ED.

Arsenic. *Chronic Poisoning.*—*Melanosis and Keratosis Arsenicalis.* A man, aged 35, suffering from lichen ruber planus, took Fowler's solution continuously for nearly two years (with the exception of one break of two months' duration) at the rate of 10 drops per diem. After using the remedy for about six months, the skin began to be pigmented, although the patient said nothing to the doctor. About the same time, keratosis of the hands and feet was noticeable, as well as dryness of the palms and hyperidrosis of the soles. Chronic conjunctivitis also set in after a few months' use of the arsenic. The only other symptoms were slight loss of weight (10 lbs. in eighteen months) and diminished appetite. On leaving off the drug, both keratosis and conjunctivitis improved, whilst the melanosis remained and increased still more when the use of the drug was resumed.

When the case was reported, the young man was well nourished, but was easily tired and had only a small appetite, otherwise the various functions were in order. There were no symptoms referable to the nervous system. One noticed a diffuse dark-brown coloration of the whole trunk and neck, in which latter and in the axillary folds it was most pronounced, whilst on the extremities it gradually diminished towards the periphery. The skin of the face was also quite dark, and showed here and there irregular and darker spots. The rest of the skin was covered

with close set spots varying in size from that of a pin's point to that of a hemp seed, the colour of these being that of the normal skin. In the palms of the hands the skin was somewhat hyperæmic, dry, slightly thickened and uneven, on the soles of the feet reddish, spotted, and of uneven thickness. The nails were unaltered. The conjunctiva was somewhat hyperæmic with copious lachrymation. He perspired easily, especially when asleep. There were irritated spots on the mucous membrane of mouth and tongue. No lichen ruber was visible. (*Allg. Hom. Ztg. from Hospitalstidendes*, No. 32, 1904.)—J. G. B.

Berberis Vulgaris. *Physiological and Therapeutic Action.*—Dr. Malcolm E. Douglass, of Baltimore, gives the following notes on berberis: (a) *Physiological action.*—In moderate doses it produces feverishness, inflammation of the mucous membrane from the throat to the intestines, and dysentery. It causes also inflammation of the kidneys, with hæmaturia, and acts on the venous system, causing pelvic engorgements and hæmorrhoids. Berberis depresses the functional activity of the brain as the organ of mind. Listlessness, apathy, indifference to life, melancholy, weakness of memory, absence of mind, are symptoms in this region. Heaviness, weariness, perspiration, and trembling occur with exertion. Blotch-shaped itching eruptions break out on the skin. Lymphatic swellings may appear at the articulations, especially on the tendo-achillis. This symptom is a characteristic indication for the use of berberis in typhoid fevers of the putrid type. (b) *Therapeutic action.*—The true spheres of action for berberis are febrile conditions of the gastric and bilious type, accompanied with rheumatism and cerebral irritation. In *subacute* inflammations of the mucous linings of the abdominal viscera it is indicated, especially if accompanied by weariness, soreness, depression, and unwillingness to move. It is also useful in jaundice with alternating symptoms of the bowels, urine, and stomach. In enuresis it is called for if there are pains from the kidneys to the bladder, with crampy, cutting pains in the bladder. The urine is pale yellow, with various sediments. (*Hahnemannian Monthly*, October, 1905, p. 749.)—ED.

Berberis Vulgaris. *Therapeutic Indications.*—Dr. Edward Cranch offers an interesting summary of the therapeutic uses of berberis vulgaris. The class of case calling for its use is the chronic gouty, with histories of gravel, old eczema, joint affections, pruritis, stomatitis, and ophthalmia, the special keynote being pain over the right kidney, radiating forward over the crest of the

ilium. All berberis pains radiate, are not worse by pressure or movement, but worse in various attitudes, especially standing, and active exercise. Sometimes temporary relief after brief exercise. The metatarsus and metacarpus are often the seat of pain, as if sprained. The urinary secretion is always increased when the action of the drug is favourable. Berberis acts well in fleshy persons, good livers, but with little endurance. An often verified symptom is a nervous sensation, as of a tight cap pressing upon the whole scalp. The drug has been successfully used in common acne. (*Hahnemannian Monthly*, October, p. 736.)—ED.

Carbolic Acid. *A Case of Poisoning.*—Henri A., aged 8 years, was admitted into the Hahnemann Hospital, Paris, two hours after swallowing the greater part of two mouthfuls of carbolic acid such as is used for disinfecting purposes. He had already been treated by an emetic (ipecacuanha), a purgative (magnesia), and by repeated washing out of the stomach with dilute solution of sulphate of soda. When admitted he was absolutely inert, the muscular relaxation being complete. On being undressed, the skin was found livid and cold, and bathed in clammy sweat. All reflexes, cutaneous and tendinous, were abolished, and there was total analgesia and anæsthesia. The stomach tube was easily introduced owing to the absence of pharyngeal reflex. Pulse and respiration were both imperceptible. The extremities were icy cold, the pupils strongly dilated, and the eyelids in a state of slight ptosis. Blood taken from the arm was dark brown, almost blackish, and coagulated more slowly than normal.

After one and a half hours' treatment sensibility returned, and he cried out lustily when the skin was pricked; the body gradually became warmer, pulse and respiration were perceptible, and the pupils contracted. Later on he passed some blackish urine, and shortly afterwards a normal stool. Solid food was withheld until the tenth day, and on the seventeenth day he was discharged cured. (*Revue Homœop. Française*, November, 1905, p. 420.)—J. G. B.

Chorea. *Drug Treatment.*—Dr. Grace Stevens, in an article on chorea, mentions the following as the principal medicines to be used in that complaint, and gives the indications:—

(1) *Agaricus*.—All degrees of movements from slight twitching of single muscles to a dance-like turning of the whole body, or there may be an attack crosswise, one upper and one lower extremity, or *vice versâ*. Besides this, there is sensitiveness of

the lumbar vertebræ, swelling of the cervical glands, a ravenous appetite, with difficult swallowing, and general aggravation during the approach of a thunderstorm.

(2) *Belladonna*.—When the attack has come on after a fright or some strong excitement. The movements are violent. The patient throws his body forward and backward in lying, or bores his head into the pillow. There is apt to be sore throat and numbness of the fingers.

(3) *Cimicifuga*.—Chorea chiefly confined to the left side. Aggravation during menstruation or when the menses have been suppressed. Rheumatic history. Kent gives the symptom that any part of the body lain upon or otherwise pressed begins at once to twitch and continues till the pressure is removed.

(4) *Cocculus Indicus*.—When the choreic state has been induced by lack of sleep. Exhaustion, with falling asleep of the limbs and a tendency towards paralysis. Movements are apt to be confined to the right arm and leg.

(5) *Natrum Muriaticum*.—In chronic cases, after a fright, or the suppression of an eruption. Melancholia, general exhaustion.

(6) *Sepia*.—Stammering speech and any attempt to speak produces jerking of the facial muscles. Constant desire to change position and place. Ringworm eruptions.

(7) *Causticum*.—When the right side and eyeballs are affected. The tongue and muscles of the palate are also weakened and paralysed, so there is great difficulty in talking or swallowing.

Cuprum, hyoscyanus, and stramonium are all useful in the type of spasm peculiar to each remedy and with the characteristic accompanying symptoms. Stubborn cases are often cured by a deep-acting, antipsoric remedy like calc. carb. or sulphur, showing the necessity of constitutional treatment in eradicating the underlying cause. (*The Medical Counsellor*, July, 1905).—T. G. S.

Dysmenorrhœa. *Electrical Treatment*.—Dr. Neiswanger, of Chicago, believes most cases of dysmenorrhœa to be due to an undeveloped uterus or to an obstruction of some kind. To cause development of the uterus he employs electricity, using both galvanism and faradism. An olive-pointed electrode is introduced into the external os and connected with the negative pole, the positive pole being attached to a large abdominal pad, and from 5 to 7 milliampères of current are turned on. Hydrogen froth will be seen coming out round the edge of the olive, the alkaline action of the negative pole causes the tissue to become soft and slippery, and the instrument slowly goes forward till it passes the internal

os and is in the fundus. The galvanic current is then turned off and a slowly-interrupted faradic current switched on. At the second treatment, in about three days the same sound is introduced without the aid of galvanism, and faradism again used. At the third sitting a larger sound is introduced by the aid of galvanism as on the first occasion, and is followed by faradism. These processes are repeated, and Dr. Neiswanger claims that, after eighteen or twenty treatments, he has developed a uterus of $1\frac{1}{2}$ inches in length to one of $2\frac{1}{2}$ inches.

Membranous dysmenorrhœa he treats by introducing into the uterus a metal electrode with $1\frac{1}{4}$ inches metal tip mounted on an insulated staff. This electrode is attached to the negative pole, and a current of 30 to 40 milliampères is passed for a period of ten minutes. This proceeding is repeated twice a week during the interval between the periods. It has the effect of liquefying the endometrium, which passes off as menstrual fluid. A treatment covering two menstrual cycles is sufficient to cure the condition.

For the treatment of menorrhagia he uses a positive electrode placed in the posterior vault of the vagina, with a negative pad on the abdomen, and employs a current of 30 to 40 milliampères for ten minutes three times a week for the three weeks preceding the menstrual flow. For amenorrhœa he employs the same means, but reverses the poles. (*North American Journal of Homœopathy*, November, 1905.)—T. G. S.

Formic Acid and the Formiates. *Effects on Muscles and Urine.*—Formic acid increases muscular strength in proportions that must be as much as five-fold, it augments the activity of the muscles and their resistance to fatigue, it acts on the entire muscular system, both striated and unstriated fibres. The effect is felt quickly, inside of twenty-four hours a number of persons to whom formic acid or sodium formiate was given, remarking that they felt stronger and more "fit" in ordinary walking. The effect lasts for eight to ten days after the drug has been taken. Under its influence the painful effect caused by repeated contractions is very noticeably lessened, while the tired muscles quickly recover their energy. In Drs. Huchard and Treidel's own persons, these effects appeared to cease in five days after ceasing the drug. The presence of this acid probably explains the activity, strength, vigour and endurance, of certain working insects, and particularly ants, which are able to carry loads out of proportion to their size. The presence of this acid in the glands of the nettle plant, in tamarind fruit, as well as in pine nettles, &c., explains (?) also the

vogue of certain remedies drawn from these vegetables. Germination is hastened in agricultural pursuits by the use of formic acid 1 to 1000. *Diuretic effect.*—The urinary secretion is very markedly and rapidly increased with the three following salts: the formiate of lithium, sodium, and potassium. Most of the formiate salts pass into the urine without decomposition. Formic acid appears in the urine about a quarter of an hour after injection of a formiate. The first urine passed is always thick and slightly alkaline, and contains more formiate than that passed later. After the third or fourth time the urine becomes transparent and acid once more. The elimination lasts four to six days, or with larger doses up to eight days. The ratio between absorption and elimination is fairly constant. The diuretic effect is very evident. It is produced rapidly the first day, and disappears a day or two after the drug is discontinued. In the majority of cases there is a greater elimination of products of disassimilation, particularly for urea, which more than other products rises under the action of the formiate; uric acid does not seem to be eliminated any more freely than without the drug. The formiate of sodium is very slightly toxic. Eleven grains of pure sodium formiate were injected into the circulation of a dog, weighing 11 kilos. In a quarter of an hour mucous vomiting occurred. No other symptoms manifested themselves. With a dog of average weight, 60 grains were necessary to produce death. (Dr. Huchard, of Paris, in *International Clinics*, vol. iii., 15th series, 1905, p. 46.)—ED.

Lupus and some other Tuberculous Manifestations. *Treatment by Heliotherapy.*—Vidal, at a recent sitting of the Académie de Médecine, reported several most interesting observations demonstrating the cure of lupus and white swelling which had resisted all previous remedial measures. The treatment is very simple: it consists in exposing the affected parts to the direct rays of the sun for periods varying from four to six hours daily, and to be effective requires to be continued steadily for several weeks. (*L'Art Médical*, October, 1905, p. 302.)—J. G. B.

Lycopodium in Hernia.—Dr. A. C. Murkerjee advises the use of lycopodium as an external application in cases of hernia, both reducible and irreducible, and strangulated, also in enteritis. He applies a compress saturated with a solution of lycopodium in the proportion of m v. of mother tincture to an ounce of water to the hernia day and night, and relates a case where the hernia had been present for three days, and all efforts at taxis, as well as the application of ice-bags, had failed to reduce it. A compress

saturated with the lycopodium solution was applied over night, and the next morning the hernia was found to be reduced. (*Homœopathic Recorder*, August, 1905.)—T. G. S.

Phosphorus. *Action upon the Coagulability of the Blood.*—MM. Doyon, Morel and Kareff, have found that subacute phosphorus poisoning causes in dogs:—(a) Fatty degeneration of the liver. (b) Disappearance of fibrinogen in the blood. (c) Incoagulability of the blood.

The modifications of the blood appear to depend strictly upon the hepatic lesions; the more pronounced the fatty degeneration, the less fibrinogen there is. When the plasma still contains an appreciable quantity of fibrinogen a clot may form, but it disintegrates easily and partly dissolves on slight agitation.

If an autopsy be performed upon animals which have been bled immediately before death, we never find the slightest clot either in the heart, the vena portæ, or the vessels generally. If the autopsy be performed some time after death produced by phosphorus, clots may be found in those cases where an appreciable quantity of fibrinogen was present. Doyon maintains that the disappearance of fibrinogen is caused entirely by the hepatic, and, not as Corin and Anseaux thought, by the intestinal changes. (*L'Art Medical*, August, 1905, p. 144.)—J. G. B.

Radium. *Some Curative Effects.*—Rehns, using applications of from 10 to 30 milligrams of pure radium bromide, found in tabetic patients that there was a return of cutaneous sensibility at the points exposed to the rays. This restoration included all the different cutaneous æsthesiæ, those, namely, of heat, of puncture, and of contact; it is more or less complete, seems to require the presence of a fairly strong erythema, but extends to a distance of several centimetres round the point of application. Applied to the forehead of a man suffering from leprosy, the return of sensation was realised in the same manner, except that in this case the effect upon sensation appeared to precede the appearance of dermic lesions. (*L'Art Medical*, August, 1905, p. 145.)—J. G. B.

Radium in Cancer.—Dr. Harvey King gave, on May 2, 1905, a demonstration before the students in the Flower Hospital, New York, of his method of treating cancer by inserting into the growth celluloid pencils coated with a solution of radium. These pencils are, he said, equally active as radium in tubes, and are much more adaptable in most cases. The power depends in each case on the degree of radio-activity. Besides being more adaptable, there is another advantage, viz., that radium in solution used as

a coating on pencils is much cheaper than the solid substance in tubes. Dr. King mentioned two cases which had come under his observation in which the use of radium pencils had been successful. One was that of a man who was treated for cancer of the tongue, and the other patient had cancer of the foot. In both cases the growth had disappeared. (*The Chironian*, June, 1905.)—T. G. S.

Saffron. *Poisoning.*—Ferraris saw a young woman of 26 who had been seized in the night with violent colic, vomiting, and diarrhœa, soon followed by convulsions, delirium, and coma. When admitted into hospital she was unconscious and died a few hours later. At the medico-legal *post-mortem* examination the encephalon was found healthy, as were also the thoracic viscera, save for a slight degree of congestion of both bases. The kidneys showed signs of congestion and recent inflammation, and the bladder contained about two ounces of bloody urine. The ovaries were in full menstrual phase, otherwise the genitalia were absolutely normal, and the uterus was of the virginal type. The digestive tube contained a large quantity of a magma, consisting almost entirely of saffron, but its walls were absolutely healthy, showing neither erosions nor hæmorrhages. Care was taken to make sure that no other abortifacients were present along with the saffron, and death could only be attributed to the latter substance, although the reasons for taking it remained mysterious, as there was no trace of pregnancy. (*Gazz. degli. Osped.*, March, 1905.)—J. G. B.

Sulphur in Facial Neuralgia.—Dr. M. E. Douglas narrates the case of Mrs. J. M., aged 60, who for twenty-eight years had suffered from excruciating pains in her face. Both sides were involved, but the left the worse; lips and tongue affected; worse by spells, though the pain never entirely went, and prevented sleep. The slightest motion of the face, or moving the lips as in talking, or bringing the lips in contact, caused frightful pain. The pain was shooting, darting, burning, tearing, drawing—in fact every form of pain. She had been under allopathic care, and had taken various narcotics, and had undergone nerve stretching and excision of the nerves, all to no purpose. It was elicited that, when a girl of 17, she had the itch, which was cured by some ointment prescribed by a physician. She was accordingly given sulphur (dose and frequency not stated). A fine eczema capitis soon came out, and the neuralgia pains disappeared as if by magic. The eczema was slow in healing, and the patient, becoming im-

patient, consulted an allopathic physician, who gave her an ointment, with the effect of causing the eczema to disappear, but the neuralgia returned. No endeavours could bring the eruption back, nor mitigate the neuralgia, and the patient ultimately died from slow starvation. (*American Physician*, May, 1905.)—T. G. S.

Tobacco. *Effects on the Throat.*—Langmaid, in the *Boston Medical and Surgical Journal* for June, 1905, gives an account of the effects of tobacco on the throat based on clinical evidence. These effects are briefly a form of nasopharyngitis and tracheitis, which may become chronic, revealed by the symptom "hemming," or a morning cough, the latter being in some cases so severe as to cause vomiting. The nasopharyngitis may be acute in the winter, when it is accompanied by a distressing night cough of a convulsive nature. The hoarseness of public singers is frequently due to tobacco, in whom the pharynx and larynx may be found hyperæmic, with an excessive secretion of glutinous mucus, and paresis of the intrinsic laryngeal muscles. Deep voices are not so readily affected by tobacco as high voices. (*Therapeutic Gazette*, October, p. 694.)—ED.

JOURNAL
OF THE
British Homœopathic Society

No. 2.

APRIL, 1906.

VOL. XIV.

All communications and exchanges to be sent to

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THE RESOURCES OF HOMŒOPATHY.¹

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“I BELIEVE in the law of Similars and spell *Curantur* with an ‘a,’ and I believe in the single remedy, for I have seen it act wonderfully; I also believe in letting the medicine act out before repeating.” You will find this synopsis of homœopathic philosophy and practice contained in the *Medical Advance* of June, 1903. The author of it is Dr. Axell, a graduate of the Hering College of Homœopathy, now in practice at Ostersund in Sweden. Besides this confession of faith, Dr. Axell’s paper contains a most interesting account of a popular movement in favour of homœopathy, probably unparalleled since the days of Hahnemann. In the course of a few months, between January and May, 1903, homœopathy had won over thousands of adherents, and as a result had roused the bitterest enmity

¹ Presented to the Liverpool Branch, November 9, 1905.

of the "regulars" and of chemists throughout the whole northern regions of Sweden. So great had been the injury inflicted upon the *amour propre*—not to mention the pockets—of the representatives of these vested interests, that, just as in Hahnemann's day, the machinery of the law had been put into operation in order to stamp out the accursed thing. The situation thus created was a most interesting one and I propose, for the benefit of those of you who may not have access to the journal referred to, to give a brief outline of it.

Homœopathy is not recognised in Swedish law, and it may therefore be considered a technical offence to practise it, the maximum penalty for so doing amounting to four dollars. On the other hand, homœopathy does not come under the "quack" law of Sweden, as the definition in that law of a quack is "one who sells poisonous materials," which only chemists are allowed to sell on doctors' prescriptions. The practitioners of homœopathy are not, it would therefore appear, liable to any criminal prosecution, nor can the practice of it be prohibited. In the present instance, Dr. Axell had already, up to the date of writing, been twice summoned before the Court and fined the four dollars, but the farcical nature of the proceedings may be gathered from the fact, that on the last occasion, out of a jury of twelve men, nine were Dr. Axell's own patients, and that the judge had openly acknowledged his sympathy with the system.

These events took place over two years ago. In September of this year (1905), I had the pleasure of meeting Dr. Grouleff, another Hering College graduate, who passed through Liverpool *en route* to Ostersund. From him I learned that this outburst in favour of homœopathy had proved no mere mushroom-like and evanescent craze, and that the system had steadily maintained its hold upon the minds of all classes of the community to such an extent that Drs. Axell and Holst were quite unable to cope with the work which offered. They had, therefore, been obliged to apply, through their Alma Mater, for further assistance, which Dr. Grouleff was then on his way to afford. One ventures to think that this record of work, based upon strict

Hahnemannian philosophy, forms a most excellent testimony to the resources of homœopathy, and that in contrast with such enthusiasm and evident success, the comparatively tame and lifeless interpretation and exposition of the same great natural law of cure which passes current amongst us as homœopathy to-day leaves much to be desired. In this respect, I believe, our present position compares unfavourably with what obtained in the earlier days of homœopathy in Great Britain. In those days homœopathy was a factor of very considerable moment in the world of medicine, judging not merely by the jealousy and the controversies which it gave rise to, but also by the success which attended it. To-day homœopathy threatens, unless we exponents of it once again take up a strong position in support of it, to become lost in a plethora of purely empirical facts and data. Allopathy has so nearly, yet for the most part unwittingly, approached towards homœopathy not only in respect of dose, but also in many cases in *rationale*, that open jealousy and hostility on the part of the profession at large is dying out. Yet this cessation of active opposition, to my mind, constitutes a very real danger to homœopathy and necessitates all the greater insistence being made upon the law *similia similibus curantur* and its adjuncts. We ought to bear in mind that in the absence of a frank acknowledgement of that law the leavening process which is going on in orthodox medicine through the acquisition from our school of "tips" forms no real advance in the science, and but little help in the practice of medicine. This crypto-homœopathy amongst allopaths has weakened the hold which avowed homœopaths now have upon the minds of the laity compared to that which the earlier exponents of homœopathy exercised. But the question we have to ask ourselves now is: Does the presence of this crypto-homœopathy in the dominant school wholly account for the comparatively insignificant attention which homœopathy now receives? May not the change be due in part at least to our own shortcomings, to a deficiency in our knowledge of the resources of homœopathy and a consequent feebleness in our efforts to carry out the system in

practice? Do we not all resort too readily, at the first sign of difficulty or of danger, to methods other than those sanctioned by our law of cure, thus weakening our cause and giving occasion for criticism and for offence to those of the profession who would deny to us the right to call ourselves homœopaths? To my mind such liberalism in thought and in action has been and is to blame, seeing that the ready aid thus afforded militates very strongly against the closer study of the philosophy of homœopathy, without which no one need expect to make much progress in the practice of the art.

I should like to preface my further remarks by a word of apology and of explanation for attempting to consider such a comprehensive subject, one which has already been written upon by very many abler and more experienced men, as the *Resources of Homœopathy*. My only excuse is that the subject is one in the treatment of which the personal factor, represented in the mental attitude or bias of the observer, plays a peculiarly important part, and that any contribution to the subject, no matter how halting and incomplete it may be, merits attention as an exposition not only of the author's methods of practice, but also of the ideals and principles which animate him.

"I believe in the law of Similars and spell *curantur* with an 'a.'" With this confession of faith of Dr. Axell I heartily agree. *Similia similibus curantur* is the bed-rock principle of homœopathy, upon which the whole superstructure depends. Like Carroll Dunham (*vide* "The Science of Therapeutics"), I believe that the maxim really embodies a great natural law of cure comparable, in some respects, to that of gravitation in matters terrestrial. I do not mean by introducing a qualifying phrase, "in some respects," to impugn the universality of the law—that I thoroughly believe in—but one is obliged to admit the fact that the difficulty imposed by our inadequate knowledge of remedies and by our inability to always read aright the sign manual of disease, introduces an element of limitation and of uncertainty not to be found in the workings of the law of gravitation; whilst, therefore, we must admit the short-

comings which our too limited human capabilities impose, we, nevertheless, believe in the maxim as law, and consider we are warranted in so doing when we remember the history of its discovery and of its subsequent evolution. Hahnemann, you will remember, had practically given up the practice of medicine, so conscious was he of the uselessness and even harmfulness of the methods in vogue in his day. In lieu of this, to him, doubtfully honest method of gaining subsistence, he betook himself to literary pursuits, to the translation of works of chemistry and of medicine into German. Amongst other works that of Cullen on *Materia Medica* occupied his attention, and whilst translating this book, "he was struck by the parallelism between the symptoms produced by cinchona and those of the disease—ague, which it was used to cure" "pondering on this germ-idea, this suggestive parallelism, the intellectual equipment of Hahnemann served him well; he perceived in this the promise and potency of better things. Adopting the Baconian method of experiment, he tried the drug on himself, and from that hour the Homœopathic law took shape and form. Based on the true inductive methods of observation and experiment, the law has been continuously verified, until now it ranks as an induction of widest and most general value." "The criterion of a law of Nature is that it is capable of—is that it receives—continuous verification in positive results from all workers who apply it in practice." "This, then, is the scientific basis of homœopathy; a natural law, fixed and persistent; a part of the cosmic order. From the time of its framing it has needed no restatement; the increasing years have only emphasised its exact correspondence with the facts which it was formulated to represent."

This passage from Dr. Burford's address on "Homœopathy, its Polity and Policy," so ably sums up the genesis of the law and the soundness of it, that I need offer no apology for thus quoting *in extenso*. Hahnemann was careful to point out that the principle contained in the law had been noted from time to time by various observers from the time of Hippocrates downwards. It was reserved to Hahnemann to

give a full and adequate expression to a truth which hitherto had been but vaguely seen and appreciated. He was not, however, content with merely formulating the law, but, philosopher like, he attempted to explain the *modus operandi* of it, and the speculation thus entered upon, coupled with later ideas and conclusions which the further application of the law in daily practice suggested to him, produced a body of philosophy second only in importance to the original discovery—that of the law itself. I have already dealt in a previous paper with the first of these accessory tenets, viz., the doctrine of a vital force, and therefore content myself with re-affirming my belief in it. To-night I want to take up the consideration of the later developments contained in Hahnemann's theory of (1) dynamisation and (2) of chronic diseases.

(1) DYNAMISATION.

Hahnemann found in the course of his practice that, in the presence of the morbid sensitivity which characterised the diseased state, the doses of the similarly acting drugs which were required to cure were far removed from those which he had hitherto been in the habit of using. Accordingly he adopted the uniform method of attenuation with which we are all familiar. To his astonishment, he found that the process which he originally looked upon as a mere dilution could be carried much further—up to the 30th centesimal was the limit he at one time proposed—than could *a priori* have been expected or even credited, and he then came to see that whilst from the physical standpoint the process was undoubtedly one of dilution—but dilution with strictly limited quantities, be it remembered—yet from the clinical point of view, dynamisation, or, as I should prefer to express it, the evolution or freeing of the forces inherent to, but latent in, the crude drug, was what actually took place. The trend of modern science is distinctly in favour of Hahnemann's theory of dynamisation based, as it is, upon the effect which simple attenuation may have in rendering a harmless and inert substance capable of evidencing new and strange, not to say powerful, properties. One might cite the

now classical experiment of Sir William Crookes, who, experimenting with simple glass tubes with electric conductors inset at the extremities, and filled with atmospheres of varying densities, found that the passage of electricity produced no result in the presence of normal atmospheric pressure, but that when under the air-pump the air had been withdrawn down to one-millionth of its normal density, the electricity now brought about a reaction, and the previously inert molecules, having now, so to speak, elbow-room, were hurled up and down the cylinder with a force which either fused the glass by heating, or actually penetrated it as with shot-holes. The crux, however, of the whole theory of dynamisation is that the active principle of drugs may be, provided the circumstances are favourable, imparted to the media by which they are surrounded. This pretension has in the past evoked much controversy and not a little ridicule, the latter owing to the undemonstrable nature of the claim apart from its clinical verification. Now, however, we can point to a precisely similar process of diffusion of active properties from subject to media, taking place in Nature and also experimentally in laboratories. I refer to the phenomena of radio-activity, which are of such interest and importance to us homœopaths that I have abstracted the following passage dealing with them and their relation to Hahnemann's dynamisation theory from a paper by Dr. Heysinger, of Philadelphia. Dr. Heysinger, writing in the June number (1905) of the *North American Journal of Homœopathy*, says: "Take the case of radium and its salts. Here we have bodies in a constant state of ebullition and activity; on every hand they give off radio-active particles with a force sufficient to penetrate opaque bodies . . . which will produce burns on the human skin, comparable to which that of burning phosphorus is but trifling; and lastly, which will impart the same forces to media in which they happen to be suitably enclosed, so that gallons and barrels of water may thus be infected (so to speak) with the active properties of this insignificant, almost microscopic, salt. Any one who has looked into the eyepiece of a spintharoscope, and has seen the coruscating

fireworks which fill the field of vision, and who realises that such microscopic fragments will continue to throw off these active particles into space for years, without the slightest diminution of weight, bulk or energy, must admit that the virtues claimed by Hahnemann as attaching to his process of dynamisation are no longer to be looked upon as outside the pale of possibility; on the contrary, one rather thinks that now the whole field of physical science is sweeping onward to the high plane which Hahnemann by rigid experimentation had reached, long before the sun of modern science had sent its first pale slanting rays across the unknown waste."

We do not claim that the facts of radio-activity afford any direct proof of the truth of Hahnemann's dynamisation theory, but we do regard them as strong circumstantial evidence in its favour. Moreover, the behaviour of the radioactive bodies having, as Sir William Ramsay says, completely confounded the old theories, alike of substance and energy, and having demonstrated the power of the infinitesimal, we are encouraged to throw off the burden of our allegiance to material posology, thereby widening our sphere of influence, and greatly enhancing our usefulness.

(2) I now come to the consideration of Hahnemann's theory of chronic diseases, which in the later years he added to the edifice of homœopathic philosophy. Most of you will doubtless be familiar with the trenchant criticism which the late Dr. Dudgeon passed upon this later development. He pointed to the denunciations which Hahnemann certainly showered in no sparing fashion upon those physicians who, to quote Hahnemann's footnote to paragraph 1 of the Organon, "spent their time in constructing so-called systems by interviewing empty speculations and hypotheses concerning the internal essential nature of the vital processes, and the mode in which diseases originate in the invisible interior of the organism; or, who attempted to give countless explanations regarding the phenomena in diseases and their proximate cause, wrapped in unintelligible words which should sound very learned, whilst sick humanity sighs in vain for aid. Of such learned reveries we have had quite enough, and it is

now high time that all who call themselves physicians should at length cease to deride suffering mankind with mere talk and *begin now to act, i.e., really to help and cure.*" Dudgeon's criticism, too, is worth quoting: "After all this, we would hardly have expected to meet Hahnemann in the domain of pathological hypotheses, and actually promulgating a theory of the origin of all chronic diseases. And yet such is the case, and we shall find that his doctrine of chronic disease is an attempt at a dogmatical explanation of the essential nature of a vast proportion of the maladies that afflict mankind, and as all Hahnemann's views were made subservient to his therapeutics, this pathological hypothesis of his was the foundation of a peculiar therapia, differing in some essential particulars from what he had hitherto taught." It cannot be denied that Hahnemann in his theory of chronic diseases has entered into the field of pathological hypotheses, but I would venture to defend his so doing in spite of the animadversions which he had indulged in in the foregoing extract. What Hahnemann protested against was the practice of approaching the problem of the treatment of diseases full of ideas more or less speculative in character, concerning the nature of them and the habit of basing treatment upon such preconceived ideas. This fault, I venture to think, Hahnemann never committed. He certainly set out, *originally*, with no speculative assumptions, and on each step of the road he traversed, he was far more controlled by the facts of daily experience than swayed by speculative reasoning. The healing art is, as he pointed out in the preface to the second edition of the "Organon," in its nature a pure science of experience, and as such must rest on clear facts and on sensible phenomena, and further in it, as in the kindred sciences of physics and chemistry, merely speculative reason acting alone can have no place. But in these experimental sciences, speculative reasoning, or, as I should prefer to describe it, the method of induction, may be employed in conjunction with well-established laws, and this, I submit, was what obtained in regard to this theory of chronic disease; in other words, the previous establishment of the law *similia similibus curantur* completely removes the grava-

men of the charge which Dudgeon lays at Hahnemann's door. Just as, in the science of astronomy, a knowledge of the law of gravitation, coupled with some observed and unexplained movements of the planet Jupiter, predicated the existence of another force, and so led to the discovery of the planet Neptune, so in medicine, a knowledge of the law of similars, coupled with certain observed and unexplained facts of daily experience, predicated to Hahnemann the existence of some other force or forces which, after years of patient research and enquiry, he determined resided in the miasmatic influence which psora, syphilis and sycosis have upon the economy. In other words, I regard the theory of chronic diseases as a natural corollary of the law of similars, and, though full proof of the validity of it cannot meantime be led apart from clinical verification, I regard its ultimate demonstration as sure, sooner or later, to be attained.

In conclusion, let me say that the urgent need of homœopathy to-day seems to me to be a more general recognition of the universality of our law of cure, and the necessity of so devoted a study of the law and its adjuncts as to render it serviceable in all the difficulties and dangers of daily practice.

FOUR CASES OF ULCERATIVE ENDOCARDITIS.

*Followed by Remarks on the Nauheim Bath Treatment of Heart Cases, with the especial Reference to Carrying it out at Home.*¹

BY EDWARD M. MADDEN, M.B.EDIN., M.R.C.S.ENG.

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WITH the exception of Dr. Byres Moir's paper on "Ulcerative Endocarditis," in the first volume of the *London Homœopathic Hospital Reports* in 1891, and a paper on the same subject, also by Dr. Moir, in October,

¹ Presented to the Section of Medicine and Pathology, December 7, 1905.

1898, read before this Society, I do not know of any special reference to this disease in any of our journals or Society records in this country. Nor is this altogether surprising when we consider how little satisfactory are the results of treatment, and how little, if any, superior have been the results in those cases treated homœopathically compared with those not so treated.

But cases of this disease are so intensely interesting, and for so long a time give one the feeling that they surely *ought* to be cured, if only we could haply light on the true similitum to the condition, or the true antidote to its cause, that I hope you will pardon my taking up a short period of your time in narrating four cases of it which have come under my notice in recent years, and some of the reflections they give rise to, though I regret to say I have no case of cure to report to you.

The first case of this disease in which I recognised its true nature was really a case of my partner's, but I saw her several times with him during its earlier history, took entire charge of her for three or four weeks during his holiday in October, and continued to see her frequently with him right up till her death, so was enabled to follow the history of her case carefully throughout.

Case 1.—Mrs. B., aged 38, had had rheumatic fever when a girl of 15. Was first seen for this attack on June 9, 1899, when she gave a history of having had influenza a month before, and had never regained her health since. Complained now of erratic rheumatic pains, worse on movement, and slight pyrexia, her temperature being normal each morning, and reaching 100°, or a little over, at night. There was a soft mitral systolic bruit, but no cardiac symptoms of any severity. She was kept in bed, and had the usual treatment for, as we supposed, a subacute attack of rheumatic fever. She did not, however, improve, and by July her temperature was averaging 102° or over at night, and one day reached 104°, and she had the general appearance of one suffering from a septic fever, with heavy sweat during sleep, great depression, and failing appetite, &c. On July 25, Dr. Moir saw her in consultation with us, and diagnosed ulcerative endocarditis, and advised the use firstly of naja, which was given in the 3c. for a week, and then nuclein in 1-grain tablets, which were given her

every three hours for a fortnight, but with no apparent effect from either.

On August 20, she had a subcutaneous injection of nuclein, 10 m, on 21st of 12 m, and on 22nd and 23rd of 15 m each, but the temperature was, if anything, raised rather than lowered after them, and by this time it rarely fell below 100°, and often reached 104° or over at night.

On September 29, Dr. Moir saw her again, and, while giving a very unfavourable prognosis, he suggested the use of antistreptococcus serum injections, and also to have the blood examined for cocci, which was done with negative results. The injections of serum were begun on October 10 in 10 cc. doses, and repeated for six doses, at first daily and then on alternate days, but except for bringing out an urticarious erythema, and aggravating her tendency to vomit, it had no other effect on the patient, and none at all on the disease, which all the time was steadily advancing, and we got evidence of infarcts in the kidneys producing hæmaturia, in the lungs and probably in the spleen, and various small surface ecchymoses, while the heart was now much more definitely affected, the bruit being loud and continuous, and the patient suffering at times from acute cardiac pains and violent palpitations. The most prominent symptoms nearly all this time from the patient's point of view were, however, gastric, flatulent dyspepsia, vomiting and complete anorexia, together with great and increasing weakness, being practically all that she complained of. The hectic fever continued unabated all the time up to January 18, 1900, when it fell below normal, and remained low till her death eight days later, during the whole of which she practically took no food of any sort whatever, and finally her life just went out like a candle burned down to the socket.

Case 2.—Miss M. M., aged 29, had congenital aortic and mitral deficiency, as her mother had also, and hence had led a semi-invalid life from childhood, and had also been liable to become anæmic whenever ill or run down. In the beginning of March, 1904, she had influenza, after which she remained very weak and anæmic, and felt her cardiac weakness considerably increased, accompanied by a sense of aching and stiffness all over the left side of her chest. As she was staying away from home at this time, I treated her chiefly by correspondence and only saw her once, when she came to friends near for this purpose on April 8; I then found her heart's action very tumultuous and rapid, and the bruits considerably increased from their usual intensity.

The medicines prescribed during this stage were soda salicycl. 3c, cratægus, strych., phos. 1-300, and naja 4c.

She did not, however, as she had done after former attacks of influenza, rally in any degree under these drugs, and about the beginning of May she was found to have a mildly hectic type of fever, when I prescribed arsen. iod. 2x and naja 4c in alternation, under which she seemed to gain somewhat in her general feeling of health, but the temperature remained unaltered, and she had occasional slight rigors.

On May 31 she was brought from Midhurst, in Sussex, to Chislehurst, so as to be under my care, coming by train in an invalid carriage, but the journey tried her very much, and on her arrival she had another rigor, during which her temperature reached 103·8°.

After her arrival she was treated more or less like a consumptive, going through the "open air cure," spending as much of her day as possible on a couch in the garden or verandah, and having her windows open all night; she was also encouraged to eat as much as she could possibly take without indigestion. The disease ran a long and checkered course, with many ups and downs, but until quite the last the patient was very rarely conscious of being seriously ill, feeling chiefly weak and inclined to dyspepsia, and used constantly to refer to what she would do when she got well again.

For medicines she had, of course, a very large number, the full list of which would be too long to give here, but among the most important of them were aconite, arsen. alb. and iod., digitalis, both in tincture and infusion, naja 3x, 4c, and 6c, pyrogen 6c, echinacea, lachesis 4c, ignatia 1x, apis 3, and sulphur 30c.

I had the advantage of a consultation with Dr. Moir twice, and one of the leading old school consultants (at the urgent request of the patient's father) once, who advised subcutaneous injections of the cacodylate of soda, which was steadily given for a fortnight, but with no more tangible results than any other drug.

As is usual in cases like these, the range of temperature gradually got higher, and she developed enlargement of the liver and spleen, scanty urine with albuminuria and dropsy, until at last she sank in peaceful unconsciousness on November 2, after an illness lasting nearly eight months.

In this case also the blood was tested on three occasions, but with purely negative results: antistreptococcus serum was not used in this case.

Case 3.—Mrs. H., aged 31. Thinks she strained her heart cycling up hills about three years ago, and since then has been more or less dyspnoeic and liable to palpitation.

I first saw her on December 30, 1904, when she gave me the following history. Three months ago she had an acute attack of influenza, with a severe relapse a week later, since which she has never been free from fever of a very erratic type, probably hectic, but which she called "intermittent." She was then living thirty miles off in the wilds of Mid-Kent, and was treated by the village doctor, who apparently diagnosed it as an obstinately persistent case of influenza, and gave her large doses of quinine.

The fever was said to have ceased about three weeks ago, when she went to the seaside, but she did not regain her strength, and to-day has come to Chislehurst to be under my care, and, as she said, to be cured from the effects of being overdosed with quinine. I found her in bed with a pulse of 126, and temperature 102.5° , and sweating freely, though with no history of a rigor, so that I very much doubt whether her fever had ever quite subsided as was supposed.

She had a loud mitral systolic bruit with a considerably dilated heart, and very feeble contractions. There were no other physical signs to be found on examination, but she had entire loss of appetite, was very thirsty, and had a decided tendency to diarrhoea and colic. The urine had a specific gravity of $\cdot 10$, and showed a haze of albumen on boiling.

She was kept in bed, and carefully dieted, being fed very largely on milk and milky foods, and for medicines had ars. alb. and iod. ac. phos., bapt., and pyrogenium, but, as she was making no progress, and the arrangements for nursing at her lodgings were unsatisfactory, on January 19 I had her brought into a private ward at our Phillips' Memorial Hospital, Bromley.

The next day Dr. Watkins came over and took, from the left median basilic vein, enough blood to make an exhaustive examination, and on the 23rd he reported that he had found streptococci in moderate numbers, but no other infective organisms.

I at once wired for a supply of the antistreptococcus serum, and on the 24th injected 30 cc. of it just below the left mamma, and during the following eight days she had seven more injections of 10 cc. each; these gave her no pain, but neither did they do her any good, and after they were stopped she was a good deal troubled with erythematous blotches all about her.

On the 26th she showed signs of slight capillary embolism in the right cerebral artery, being very drowsy, tremulous and

hesitating in her speech, and in protruding the tongue ; and subsequently to this she had several purpuric eruptions appear on different parts of the body. The urine varied in amount and in the proportion of albumen it contained, the greatest amount ever found being three-tenths of a column, and though she had some œdema of the feet and legs, this was never very great, and she at no time had ascites. Further medicines administered during her illness besides those already named were *echinacea*, *naja* 3c, infusion of *digitalis* when the urine was scanty, *cacodylate of soda* in $\frac{1}{8}$ th grain tablets, *aconite*, *spigelia* 1x, and *strych. phos.* $\frac{1}{60}$, but nothing really checked the steady downward progress of the complaint, and after being semi-conscious for two days, and having some slight attacks of a convulsive nature, she died on February 25, *i.e.*, nearly two months after I had first seen her, and five months after the onset of her influenza.

In this case also I had the advantage of Dr. Moir's advice and co-operation, and he fully confirmed my diagnosis, and was very hopeless of the issue from the first.

There has been a certain generic likeness between these three cases, but my next case belongs to a different class entirely, being foudroyant in its course and coming on during the progress of an acute illness.

Case 4.—Mrs. B., aged 70, an old patient of mine, and whom I had seen safely through several attacks of bronchitis and liver disturbance, was short, fat, emphysematous, and with a somewhat feeble and probably fatty heart, though it had never showed any organic defect.

Her husband died of acute pneumonia on December 26, 1904, after an illness of only nine days, during which she had nursed him assiduously, and systematically neglected herself. On the next day she entirely collapsed and stayed in bed, had a low pulse and temperature, and could hardly take any food, but had no shivering of any sort, and I, on that day, thought it was merely the reaction after her strenuous self-restraint and over-work, coupled with grief. But on the 28th I found her feverish and with rapid respiration, and suspected at once that she was infected by her husband's pneumococci, and gave her *acon.* and *phos.*, and on the 29th I found definite evidence of acute lobar pneumonia on the lower half of the right side, which ran a severe but normal course, and by January 10 she had lost all fever, the lung was clearing up, and she appeared in a fair way to make a good

recovery. She, however, did not pick up her strength, and gave one the impression that she did not *wish* to get better, though she was very calm and cheerful to her nurses and children.

On the 17th, having tried to sit out of bed a short time, she had a slight rigor, and got very blue and faint, and her temperature soon rose to 103°, and on my next visit I found her heart very disturbed, being irregular and easily excited, while there was a rough first sound at the apex which I had never heard before. This increased gradually, and after a few days was a very pronounced loud mitral systolic bruit. The temperature now assumed a true hectic type, and she had several slight rigors followed by a very high temperature, and ended in sweating freely. On January 23 (having had one of these rigors the day before) I found a fresh patch of limited consolidation in the left base, which I have no doubt was caused by an infarction, and which caused no cough nor any respiratory difficulty. She began now to suffer from nausea, with a thickly furred, dry tongue, and diarrhoea, with pale watery and slimy stools, and a general condition of a typhoid character (without any indication of its being typhoid), and so gradually sank, till after being unconscious for over twelve hours, she died on February 1. The medicines given during this last fortnight were ars. alb. and iod., phos., stroph., pyrogenium, baptisia, lach. and sulph., while oxygen inhalations were used to meet emergencies, as well as occasional doses of brandy.

In none of these cases was I able, unfortunately, to get leave to make a *post-mortem* examination, so that, to this extent, their histories are incomplete, but I do not think there can be any doubt as to the correctness of the diagnosis.

In reviewing these cases, one sees at once that in all of them the heart had been previously defective, diseased, or weakened in some way, thus rendering them liable to become the seat of an infective invasion. The last case was a typical one of the so-called typhoid or pyæmic variety, and ran the usual rapid course so constantly associated with this form of the complaint, and there can be little doubt the infective germ here was the pneumococcus.

The first three cases, however, are somewhat peculiar in owing their origin, so far as can be ascertained, to the infection of influenza, a source rarely referred to in text-books even of recent date, but that the poison of influenza

is in many, if not in all cases, a truly septic one, besides having a marked tendency to weaken the myocardium, we have all of us had only too much experience to entertain the slightest doubt, and from what I have seen in these cases, I fancy that if the serum treatment is to be of any use, not only should it be given quite early in the case, but also—as I think Dr. Moir has already suggested—that the special serum should be used which is antitoxic to the most probable origin of the case. As the toxin of influenza, let alone its antitoxin, is still to seek, this method of treatment is not yet available for cases owing their origin to the above-mentioned cause.

Pyrogenium, which is by some considered a true homœopathic specific for all septic fevers, and has been lauded in this room as all powerful against influenza, did not appear to touch my cases at all, neither did the serpent venoms, nor the latest American antiseptic remedy, echinacea.

It was quite remarkable, however, that in all these cases the patients expressed themselves as feeling most benefit from arsen., and especially from its iodide given in the 2x or 3x strength, which we have so often found the most satisfactory restorative to enfeebled heart muscles. We could also, until quite late in the course of these cases, confidently rely on the efficacy of our drugs to relieve inter-current symptoms, such as *digitalis* in anuria, *chelidonium* in liver pain and nausea, *bryonia* for cough or constipation, and so forth, thus indicating that the responsive power of the patient was still active and that it was only needed to find the true similimum to the disease to give a very fair chance of saving the patient. So far as I can see we have no such drug as yet, for, though aconite, arsen. and the serpent poisons each cover a fair proportion of the symptoms we have to combat, in none of them does the history of their proving complete the picture sufficiently accurately to form a satisfactory homœopathic specific. Another encouraging feature of these cases is the fact that, in both those of the first series which had been from the outset under homœopathic treatment, the course of the illness was considerably longer than such cases usually run, the first case

living seven, and the second eight, months after the beginning of the septic symptoms.

I am therefore quite inclined to expect that before long we may capture this hitherto almost impregnable citadel, and I am not without hope that some valuable suggestions for adding to our effective weapons of attack will be made here to-night.

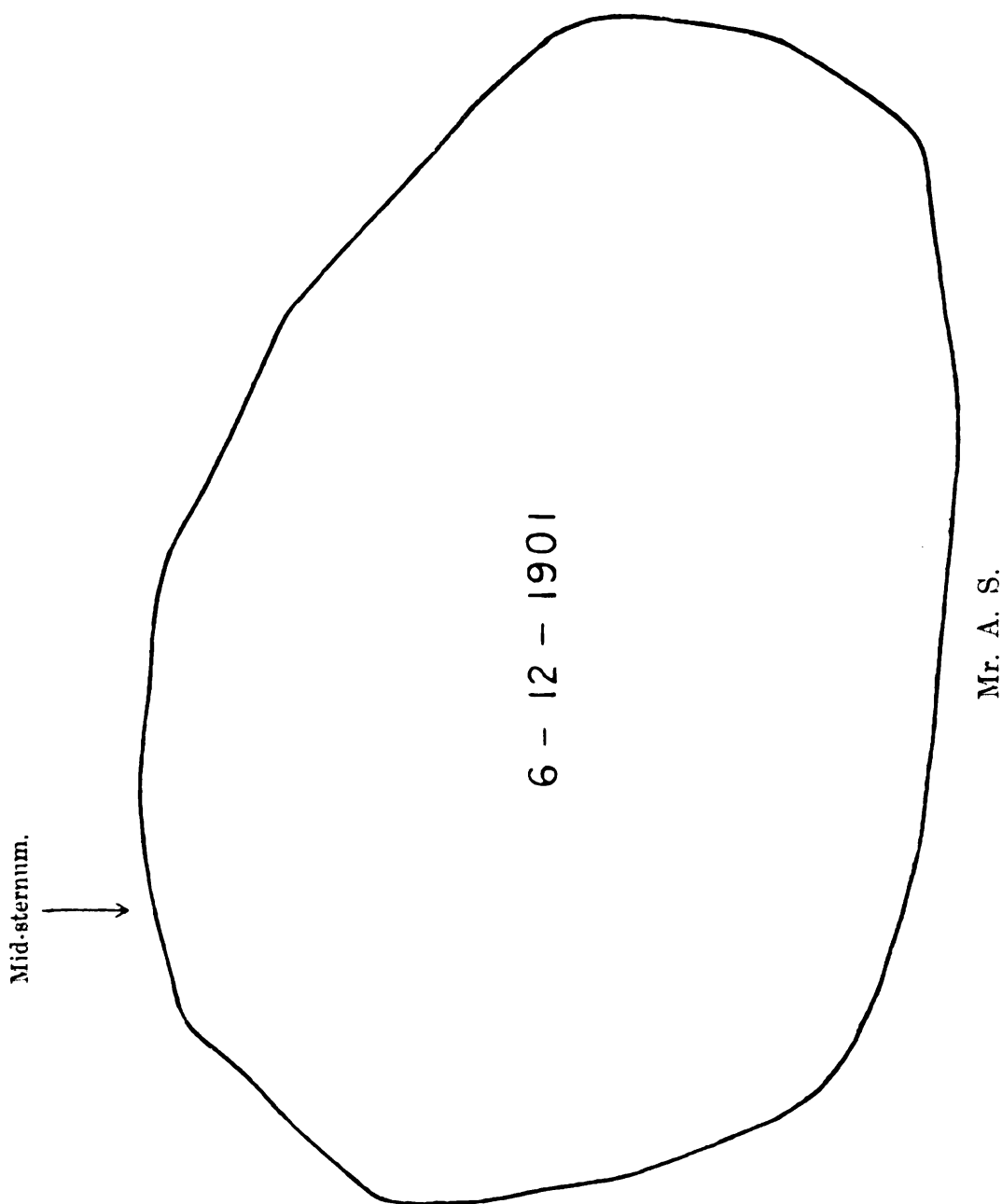
Turning now to the second part of my subject for to-night's paper, although the virtue of the baths at Nauheim in heart disease, and especially in dilatation, has been known for a long time, it is only since the work of the Drs. Schott in adding special graduated exercises to the baths that it has attained to the world-wide reputation and popularity this treatment enjoys to-day, and still more recently we have learned that the same results can be obtained in the patient's own home, by using baths artificially made to closely imitate the natural Nauheim waters.

Even now I believe that this is not as fully recognised, or at least not as fully acted upon, as it deserves to be, and it is in the hope of inducing the more frequent use of this treatment at home that I propose to bring before you a very short *résumé* of my results to-night.

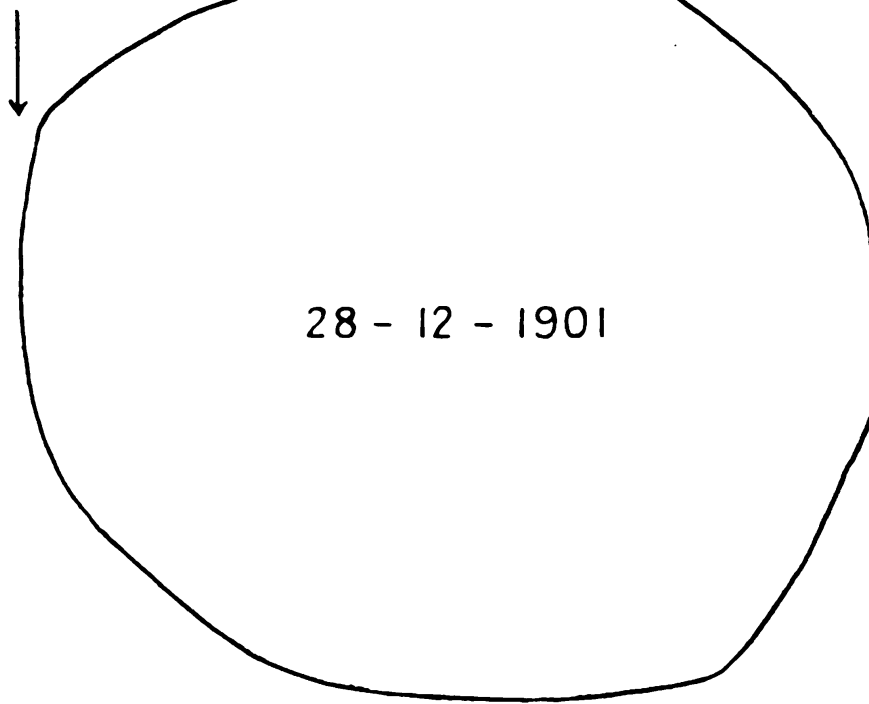
On looking through my notes of the last three or four years I find records of twenty-four cases in which I have given or ordered my patients a course of Nauheim treatment. Of these, seven (four men and three women) went to Nauheim, two of them twice, for treatment, two were treated at Malvern, one at Sidmouth and the remaining fourteen were treated by myself, eight in hospital (three men and five women) and six at their own homes (two men and four women). Although there have, of course, been individual differences in the degree of benefit derived from the treatment, I have been unable to find any advantage at all in the results obtained at Nauheim over those treated in this country. Possibly because I have been very careful in selecting suitable cases for this form of treatment, I have had no failures, and every case has benefited by it to a greater or less extent—where there has been dilatation (as

there was in most of them), this has been markedly reduced, the heart muscle has gained strength and its action become more regular and less easily excited, the patient being raised, for the time at all events, to an altogether higher plane of health.

By way of example I am sending round the tracings of the heart's dulness before, during, and at the end of the



Mid-sternum.



Mr. A. S.

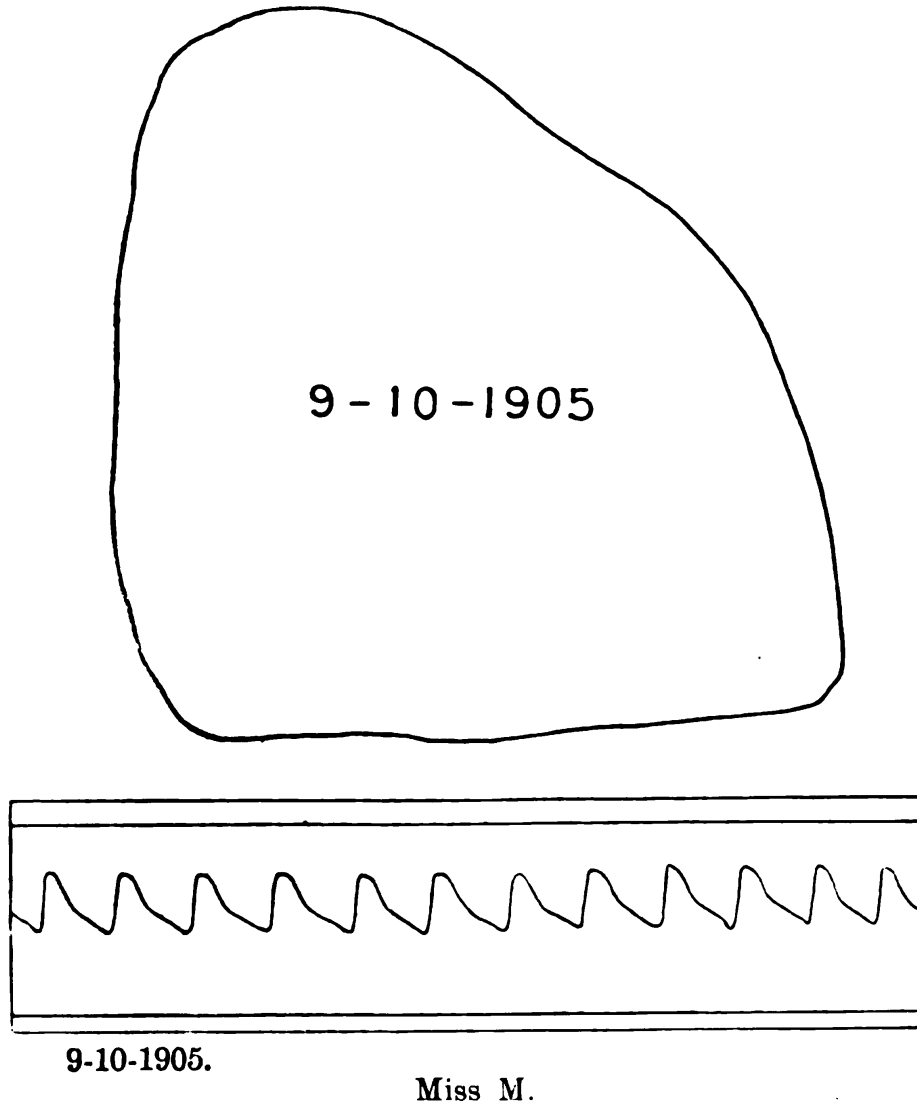
treatment of three cases treated in their own homes, together with sphygmographic tracings of the pulse in two of them, which speak for themselves.

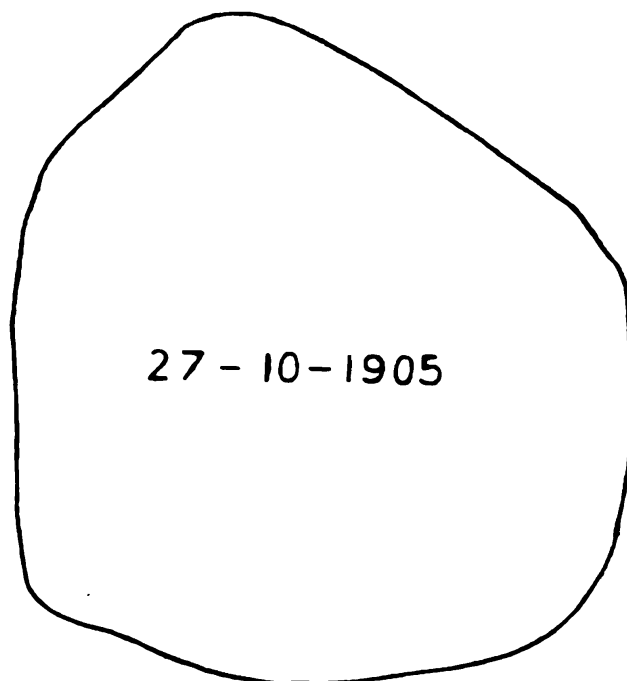
The first was a Mr. A. S., aged 74, at the time of his treatment in December, 1901, he had suffered from emphysema and bronchitis for many years, and for the last ten years at least his heart had been dilated, causing an impure mitral systolic sound and rendering him liable to severe dyspnoea on any exertion and latterly to an increasing tendency to attacks of angina. As you will see, his heart was greatly dilated, the transverse dulness being no less than $5\frac{1}{4}$ inches before beginning treatment. I obtained a good male nurse, trained to this treatment, who gave only eighteen baths, and resisting exercises, &c. At the end of this time the transverse dulness was only $3\frac{5}{8}$ inches, and the general health was so far improved that he was able to a large extent to resume active life. He hardly ever felt his old angina, until this autumn, when being much bustled

and excited during a railway journey, he had a very bad attack, after which his heart rapidly failed and he died of dropsy at the end of October. We may fairly claim that the Nauheim treatment gave him nearly four years of useful life, with comparative freedom from heart troubles.

The other two cases were both ladies, the one, Miss J., aged 65, was treated in April and May of this year; the other, Miss M., aged 75, was treated in October and November of this year, with the physical results I now show you.

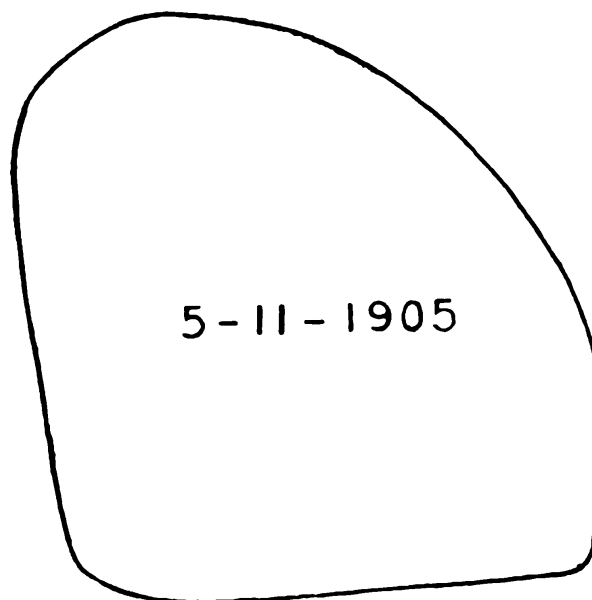
In neither of these was there any definite valve lesion, but both had dilated hearts with myasthenia cordis, and





1-11-1905.

Miss M.

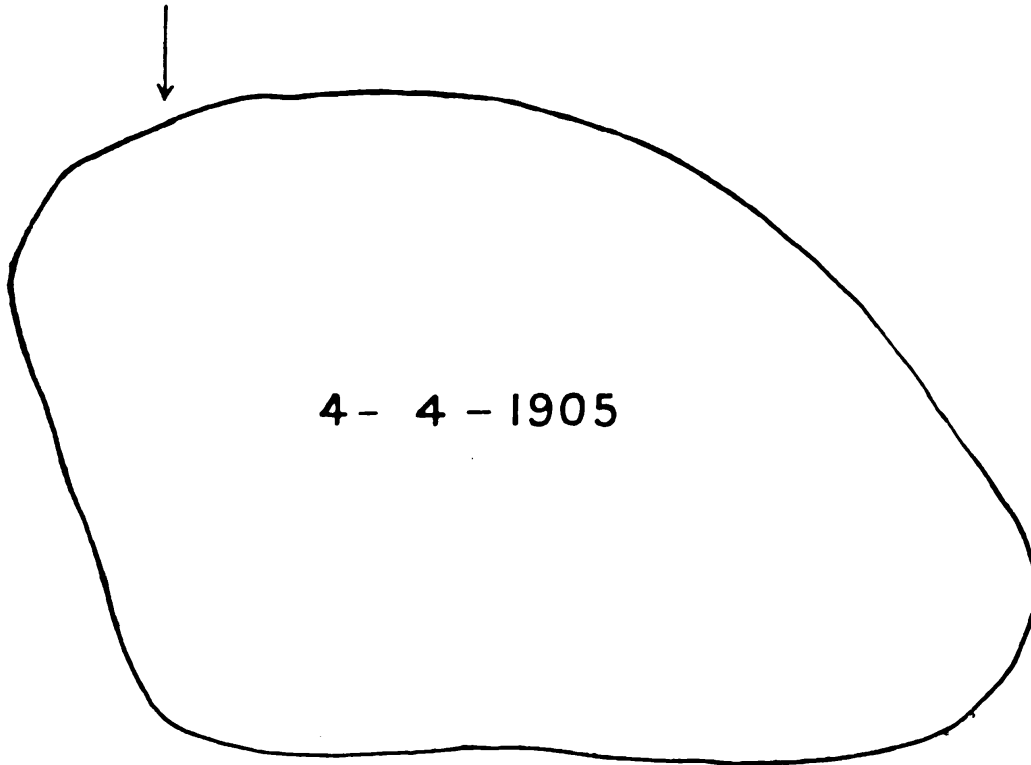


Miss M.

were liable to attacks of heart failure, with faintness, vertigo and palpitation, and in both there were slight angina-form pains with these attacks.

In each the improvement in the feeling of health and capacity for exertion has been most marked and satisfactory, and the friends are unanimous in saying they have not seen them so well for years past.

Mid-sternum.

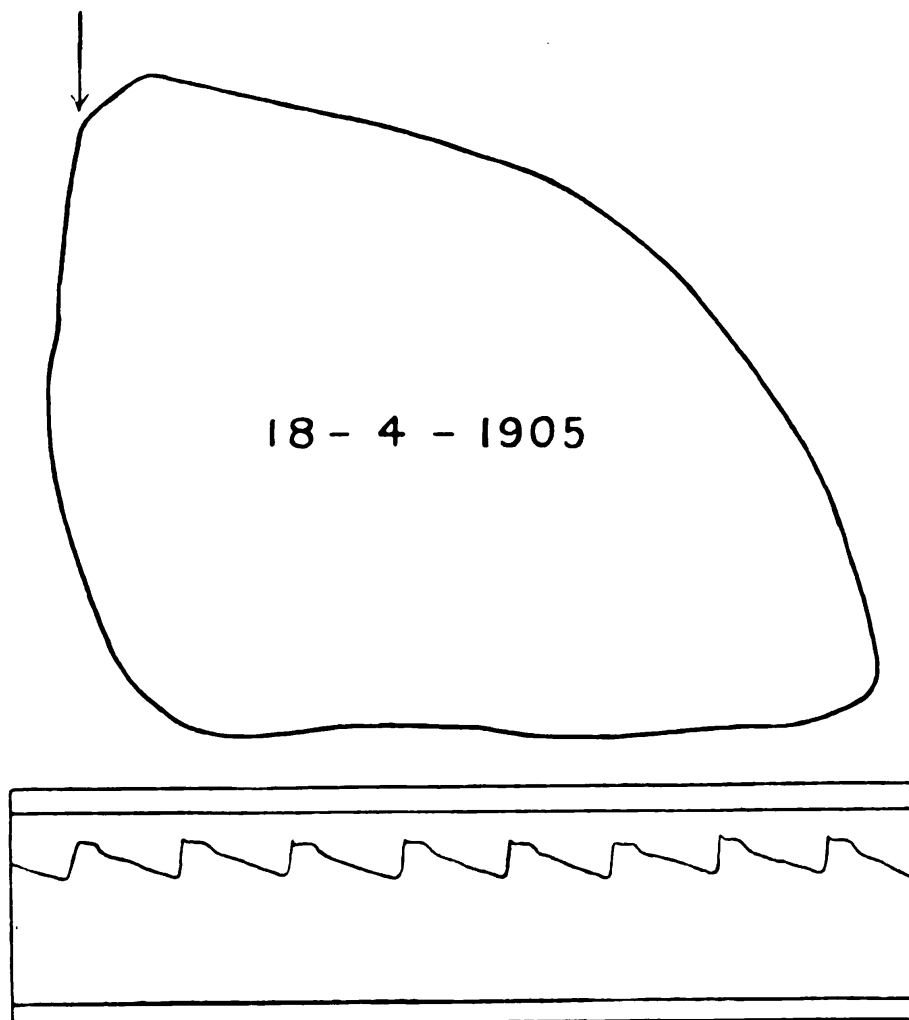


Miss J.

It is purely accidental that I have picked out cases of old people, but, if anything, the improvement has been more marked in the young and middle-aged, and, if we can get as good results as these at home, it needs no argument to prove that in very many cases it is much better to carry on this treatment at home, rather than to send our patients abroad for the purpose. To enumerate a few only of the more obvious advantages: In the first place, the treatment at Nauheim is only available for some five months in the

year ; whereas, of course, the home treatment can be done at any time, just whenever it is needed, or whenever the patient can most conveniently give up the time to it ; then, again, by staying at home the patient saves a considerable expense (often very important), saves a long journey, remains among his friends, and is surrounded by those with whose

Mid-sternum.



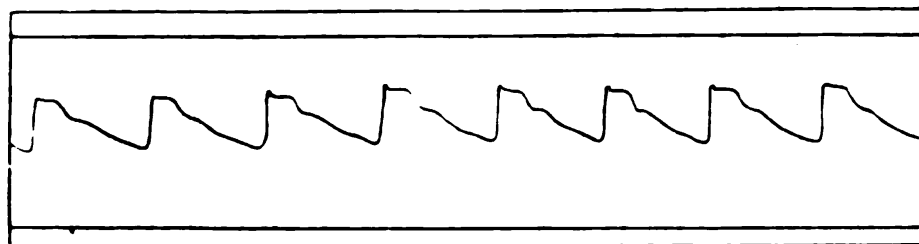
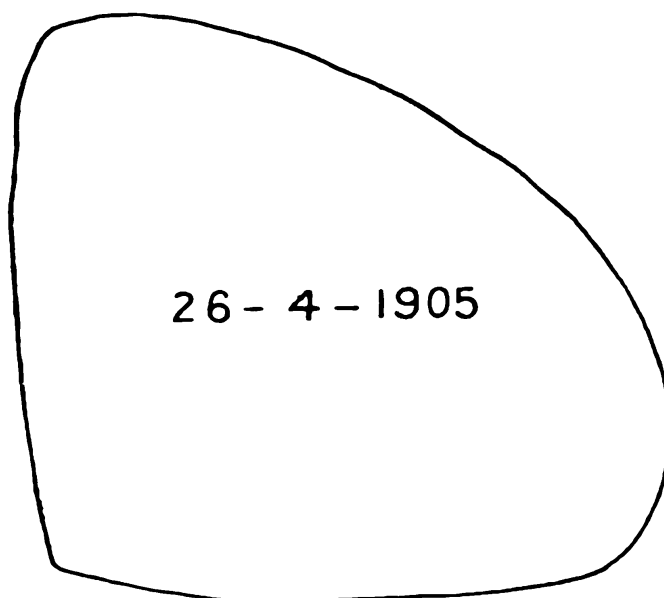
18-4-1905.

Miss J.

language he is most familiar, continues to have the food and cooking he is accustomed to (another frequently *very* important item), and is less completely separated from his ordinary work or habits of life (a doubtful advantage in many cases, but a very real one in others), and, lastly—and

this is one in which we share the advantage—he remains under the care of his own doctor, who probably understands him, and can manage him better than a complete stranger could possibly do.

It is not a very difficult treatment to carry out, or to supervise, though it certainly requires a good deal of careful



26-4-1905.

Miss J.

attention to details. In ordering the details of the baths and exercises, an individualisation of each case should always be given in writing to the nurse. With the help of such good handbooks on the subject as those written by Dr. Bezley Thorne and Dr. Joseph Kidd there is no real difficulty in giving this successfully, and the advantage to our

patient resulting from it is so real, that one should never hesitate to advise the treatment, or shirk the trouble in those cases requiring it. There is just one special suggestion I should like to make beyond what you will find in the books referred to. You will notice in the analysis of the Nauheim water that a definite quantity of the chloride of barium is found, and this is not added in the chemicals used to produce the artificial water used at home. Knowing how decidedly homœopathic this salt is to heart weakness, and especially to the tendency to atheromatous degeneration which so often accompanies those forms of it which are most benefited by this treatment, I have lately been in the habit of giving bar. mur. in 3x tablets to my patients going through this course, and have thought I could trace an appreciable increase of improvement as a result of so doing.

SLOW PULSE IN YOUTH.¹

BY BYRES MOIR, M.D.

Physician to the London Homœopathic Hospital.

My contribution to-night is a very short one, as I only wish to draw your attention to a condition which I have never seen especially referred to, and yet is, I think, worthy of considerable notice.

We are all aware, and have come across occasionally, bradycardia, or slow pulse in adults, but a similar state of the pulse is not infrequent in youth, especially during rapid growth.

I do not include the cases which follow serious illness, brain disease, or the toxæmias, of which influenza may give us plenty of examples, but to cases where, without previous illness, a slow pulse lasts a long time, or may be a permanent condition.

Roughly speaking, we may take the following as an

¹ Presented to the Section of Medicine and Pathology, December 7, 1905.

average pulse rate : infancy, 120 ; childhood, 100 ; youth, 85 ; and adult 72. So that we may consider a pulse of under 60 as a slow pulse during the period of growth ; and I may here state that I am referring to the pulse when taken in a sitting posture with the legs down.

In 1888 a committee was appointed to conduct an investigation as to the average development and conditions of brain power among the children in primary schools. This committee examined and gave a full report on 100,000 children.

In this enquiry it was determined to look at each child in the school, and take notes of all, in whom any one or more abnormal points could be observed, as well as any reported by the teachers as dull or backward pupils. Special attention was devoted to low nutrition of the body and mental dulness.

The report enters very fully into nerve symptoms, but the pulse was evidently too simple a thing to notice, and yet I am sure that slow pulse, with the feeble circulation that accompanies it, would have been found to be associated with, if not the cause of, many cases placed in the large class of " children feebly gifted mentally."

My attention was first drawn to this some years ago, when a boy was brought to me by his father, who said that he was at a public school, but was so apathetic and indifferent that the masters complained that he could not get on with his lessons and made no progress. He complained of headaches, and was said to snore at night ; his condition was so like the stupidity seen with adenoids that I sent him to Mr. Dudley Wright, who found no obstruction present.

The heart sounds were clear. Pulse varied from 54 to 60. General circulation very bad, as shown by coldness and lividity of hands and feet. His urine was free from albumen.

I advised his leaving school for a term, to live as much as possible out of doors, and to have daily gymnastic exercises under a Swede. The result was most satisfactory ; and when I saw him three months later he had put on 5 lbs. in weight, and was quite bright and active.

The next case had a very different ending. A boy, aged 11, was brought to me in April, 1900, with a history that in the

September previously, while bathing, he put his head under water, became unconscious, and was found lying at the bottom of the bath. During the next few weeks he fainted several times, and a month after had what was said by the doctor attending to be a true attack of epilepsy.

When I saw him the boy was pale and pasty, tissues very soft, not overgrown in any way. The chest development was very poor, and he could make very little difference on a deep inspiration.

The heart sounds were clear. The pulse—the average rate at this age is about 88—was 54, of very low tension.

I recommended that he should be kept from school, be as much as possible in the open air, and that he should get careful physical training, with especial attention to deep breathing, and, above all, to avoid any exercise that put extra strain upon the heart.

After the visit to town, from the fatigue of the journey, &c., he had another faint, remaining unconscious for some time. After that, though he felt faint once or twice, he had no more attacks, and when I saw him six months later he was much improved. His pulse still remained about 54, but the tension was much better. His chest expansion was $2\frac{1}{2}$ inches, from 23 to $25\frac{1}{2}$ inches. His colour was good, and his mother stated that he had been very active and seemed quite well all the summer holidays.

I was very pleased with his progress, and gave a very hopeful prognosis, saying that if he went on well for another six months he would be able to return to school. A few weeks after, however, I had a telegram to say that he had died suddenly in a gymnasium.

On making enquiries, I found that the sergeant in charge, who had been cautioned about the exercises he was to give, on that day, being so satisfied with the progress the boy had made, allowed him for the first time to pull himself up by the rings; directly after this he staggered and fell unconscious, the syncope proving fatal.

An article by the late Dr. Edward Blake, "The Influence of Certain Kinds of Breathing on the Circulatory Apparatus," explains what happens in a case like this, and the sphygmographic tracings which he gives, and which I pass round, illustrate how the syncope occurs. Holding the breath while making a strong effort may be sufficient in a feebly acting heart to cause fatal syncope.

This case emphasises the great need there is in this country for carefully trained physical instructors who have some knowledge of anatomy and physiology, for, under proper care, I believe this boy might be alive and well. It has taught me by a sharp lesson never to entrust any but healthy boys to the ordinary gymnastic instructor.

The association of epilepsy with slow pulse was of great interest to me, for I have had under my care several cases of bradycardia in adults, in which epileptiform attacks occurred. In one the attacks ceased when the bradycardia passed away, and I was full of hope that in this boy the epilepsy would be cured by improved circulation.

About the same time I saw, with Dr. Clifton, of Northampton, a girl suffering from epilepsy in whom the slow pulse was a marked feature—but I only saw the case on the one occasion.

The next case is one which illustrates the kind of youth where the slow pulse is most likely to be found, viz., in the very long, weedy youth, in whom the heart does not seem to grow in proportion to the rapid body growth.

L. Y., aged 14, was brought to me in May, 1897, with the history of always being slack and tired, and his mother complained that he would do nothing but loll about in armchairs.

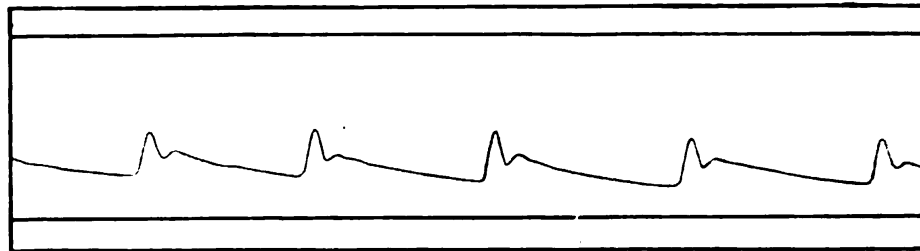
His height at 14 was just under 6 feet—5 feet 11 inches in his stockings. Weight 9 st. 2 lbs. The heart sounds were quite clear and distinct; the pulse 48, with very low tension, and I was told it often fell to 44, with blueness of the extremities (the average at this age gives 87 for the pulse).

The chest measurements were good, expansion yielding, minimum $27\frac{1}{2}$ inches, maximum 31, a difference of $3\frac{1}{2}$ inches.

My advice was much the same as in the last case—carefully graduated exercises under the supervision of an instructor who would see them done, as the boy could not be expected to take any interest in them himself. About two and a half years after this, when he was a little over 16, he had grown to 6 feet $4\frac{1}{2}$ inches. His weight was 12 st. $2\frac{1}{2}$ lbs. His pulse was usually 48, and still very low tension. He still complained of being very slack and good for nothing, but I was encouraged by finding that his chest, the maximum measurement of which had been 31 inches, now went from 31 to 35 inches on forced inspiration.

When 19 he was refused for life insurance from evidence of tubercle; on examination then I found him with a pulse of 72; temperature being 99° ; there was marked crepitus at the left apex.

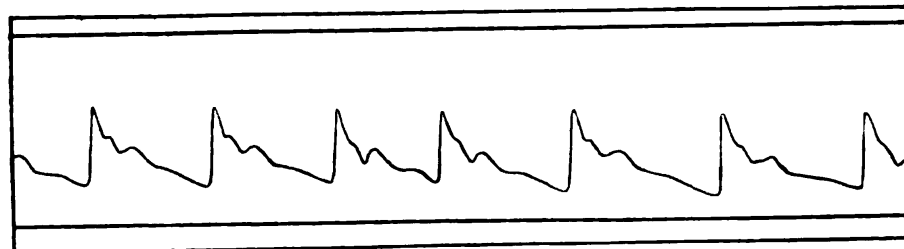
A long sea voyage, however, cleared this away. He is now engaged in an office in London, and when I overhauled him a few weeks ago, for the purpose of these notes, I was pleased to find an active, energetic young giant, a great enthusiast on Sandow and his methods. His height is now, at the age of 22, 6 feet $6\frac{3}{4}$ inches, and he has not yet done growing; weight 13 st. Chest measurements of $32\frac{1}{2}$ to 37 inches, a difference of $4\frac{1}{2}$ inches. His temperature was normal. Pulse at time of visit, 50. Taken for a week it varied between 50 and 60, reaching 56 and 60 after Sandow's exercises. On making him lie down on the sofa it fell to 42.



Pulse at age of 14.



Pulse at age of 18.



Pulse at age of 22.

The tracings which I pass round, taken at four years' interval, show very markedly the improvement in the circulation which has taken place.

This is an illustration of what has often been noted before, that a slow pulse is more frequently found in tall men, and, it is said, may be no appreciable disadvantage to them, though this I doubt, but they certainly require great care during the time of rapid growth.

Of late years the increase in stature of the modern girl has been very noticeable, but so far I have not come across any cases of slow pulse among them, and would like to learn the experience of those present.

I am not dwelling to-night upon the pathology or drug treatment of the slow pulse, but wish to emphasise the point, that with it there are associated a general feebleness both mental and physical, and that there may be also tuberculosis and epilepsy.

I shall be glad to learn what are the views of others with regard to the frequency of its occurrence, for I have come across many other cases than those I have brought forward as instances. I look upon physical exercise as an essential part of the treatment, the assistance rendered to the heart from proper expansion of the lungs being all important.

My second case shows very clearly the need for all exercises to be done only under fully trained and careful instructors. I may be wrong, but I think slow pulse is more prevalent among boys than girls, and I have no hesitation in saying that I think the reason for this is, that at the present time the girls are getting much better physical instruction in their schools than boys.

NOTES ON PULSE RATE AFTER EXERCISE.¹

BY HERBERT EDWARD DEANE, M.D.DUR., M.R.C.S., L.S.A.

Lieut.-Colonel Royal Army Medical Corps (retired); Assistant Physician to the London Homœopathic Hospital.

THE following are preliminary and rough notes on a subject on which I wish to inform myself and gather information and any hints as to further investigation from others. The line of observation is the outcome of a paper I prepared for the last Congress of the Royal Institute of Public Health on the "Irritable Heart of Soldiers, its Causation and Prevention," in which I claimed to demonstrate that the foundation of the condition was laid on the barrack square during the preliminary setting-up drill of the recruit, owing to the faulty and vicious position of attention. Further, that the foundation was strengthened, during the recruit's gymnastic course, owing to the exercises being performed regardless of the recruit's individual capacity and the functions of the chest. The only ready method of forming an idea as to results of exercise is to count the pulse rate, and sometimes to examine the heart. In the paper named I recorded observations of pulse rates before and after work, both free gymnastics and apparatus work. One instance will suffice here: I took haphazard eleven men who had been on parade from 6.45 to 7.30, marching and doing extension motions, and counted their pulses at 10 a.m. before an hour's gymnastic work, and again after; they were:—

	96	increased	to	144
	84	„	„	108
	104	„	„	116
	84	„	„	104
	96	„	„	142
	80	„	„	108
	80	„	„	108

¹ Presented to the Section of General Medicine and Pathology, December 7, 1905.

100	increased to	120
96	„ „	116
88	„ „	120
88	„ „	112

and six of these men had epigastric pulsation; and with that I found a diffused and ill-defined apex beat.

The following then struck me. What is a normal pulse rate, and what increase after exercise takes place in a healthy man, and what determines the rate of increase and what influence has breathing upon it?

Literature generally on the subject contains generalities as to exercise increasing and strengthening the action of the heart, but they are of about as much use as such generalities usually are when we have to deal with particulars.

First, about average pulse rate. A table exists for different ages; is that average based on observations made in a lying, sitting, or standing position, or on observations made in all three positions?

Dr. Guy, of King's College Hospital, in the "Cyclopædia of Anatomy," for 1852, states from actual observations that the average pulse having its normal characters is 81 standing, 71 sitting, and 65 lying, at a mean age of 27.

Extreme results, he says, are very wide of the average (they always are, by the way!) both in male and female; for difference between standing and lying ranged from 24 to 0, between sitting and lying, 11 to 0, between standing and lying, 28 to 0.

In my own case there is usually a difference of about 10 between lying and sitting, and of about 12 between sitting and standing, but it is subject to great variations.

Regarding the effect of exercise, Dr. Guy also states (quoting Ryan Robinson) that "the pulse in a minute, of a man lying, sitting, standing, or walking at rate of two miles an hour, four miles an hour, and running as fast as he could, was 64, 68, 78, 100, 140, and 150 or more."

I have begun making observations of actual facts on men and women, who are trained gymnasts of their kind, with a view of possibly forming an opinion on them; also when undergoing gymnastic training; also on untrained

individuals. I may say at once I have to take people as I find them, which after all I think of more value than trying to put a few people under exactly similar and therefore artificial conditions. It is scarcely possible to place people under exactly similar conditions. If you try to feed people alike, some will be upset by food on which others get above themselves.

The first point I noticed was the great variation of pulse rate, and the rarity with which the average for adults as per books occurred. To maintain the erect posture involves muscular action, and whether this wholly accounts for the increased pulse rate over sitting or lying is another thing; because about the same increase occurs when the change from recumbent to erect posture is made on a revolving board.

There is a modification of the normal erect attitude in the military position of "attention," which, carried out according to instructions, involves strain and more or less fixation of the chest in an inspiratory position and breathing shallower than normal. The pulses of four recruits who had been under gymnastic training for about two months were 84, 80, 80, 72, when standing simply erect. After standing two minutes at attention they were 92, 96, 88, 88. The pulse of a trained gymnastic instructor when erect was 72; after two minutes at attention, 80. The pulse of a trained instructress of Swedish gymnastics, erect, was 82; after one minute at attention 106.

Next take a class of ladies under two years' training as instructresses in physical education. A class of twenty-three in their second year of training, at 10 a.m., had a slowest pulse of 72, highest 120, average 91. After an hour's Swedish work the increase ranged from 4 to 32. Without giving all details, I may say that the lady who had increase of 32, from 76 to 108, on another occasion increased 64, from 76 to 140, with the same kind of work, and on two other occasions had increases only of 16 and 24. Another lady started with a pulse of 120, increased to 124; on another occasion started with 112, increased to 120; and on another started with 112 and increased to 140; on

another started with 84 and increased to 112. I am not yet prepared to say how long it takes the pulse to slow down in a class, as this takes time which is not available always.

Some observations on men and women, who were in various states of training, with pulse tracings taken, are here omitted.

I relate a few observations.

I took three gymnastic instructors, one of them being the man whose pulse went up eight beats after standing two seconds at attention, and the rates were 60 (the man referred to), 72 to 96, and my own 72.

After going up a rope hand over hand with legs held at right angles to the body, the rates were 64, 84, 100, and my own 84. The instructor paid no special attention to the breathing. I then set a recruit, who had attended the gymnasium for two months to try the same exercise—though he could not do it properly—his pulse went from 84 to 128, falling ten seconds later to 88. I sent another recruit, who had attended the gymnasium eleven weeks, over the bridge ladder; he went from 92 to 148, falling five seconds later to 104. About twenty seconds after the rope climbing my pulse was 72, and an instructor's 92. I set the exercise of pressing upon the parallel bars with legs held horizontally, twelve times; my pulse rose to 108 and fell to 76 on sitting down; the instructor's rose from 92 to 112, and fell to 100 on sitting.

On another occasion I got a lady instructress in Swedish gymnastics and physical training generally, to go up a slanting ladder, which she did one and a half times with arms straight; her pulse went from 96 to 112, falling in a minute or two to 96. I went up the same ladder with bent arms three times, and my pulse went from 72 to 116, falling in a minute or two to 84.

Dr. A. E. HAWKES (in the chair) said that such cases as Dr. Madden had brought forward rather filled one with despair, for how were they to improve upon Dr. Madden's methods or get better results? The cases seemed to resemble in this regard per-

icious anæmia. As to the use of the serpent venoms in endocarditis, Dr. Hayward would ask them to give crotalus a trial, because of their being more sure of its reliability. With regard to slow pulse, one was very familiar with it in young people suffering from pericarditis, but he thought that no one knew exactly why it should occur. He had never been particularly pleased with his own mental capabilities, and perhaps the reason had been that his pulse had always been a slow one, it never having exceeded 56 during many years under ordinary circumstances, but it went up very rapidly upon exercise. The set of observations brought forward by Dr. Deane was very interesting. Of course, Dr. Deane had most frequently chosen men who were very healthy. He (Dr. Hawkes) held a view—though he did not think that he could quite substantiate it—that even though no bruit was audible, one who had been the subject of a bad attack of rheumatic fever would be on a somewhat different standing from persons who had had no chorea or anything of the kind. Those who had attended confinement cases would often have noticed the extreme slowness of the pulse after normal parturition, the pulse going down to 50, or even lower than that.

Dr. NANKIVELL said that he had found in all the papers a great deal which he could thoroughly appreciate. Dr. Madden's cases of ulcerative endocarditis saddened him, but from what was known of such cases they always went from bad to worse. As to the Nauheim treatment, as was known to the members, he had given a great deal of attention to it; and he agreed that many of the cases were better treated at home than at Nauheim, but there were many cases which it was best to treat at Nauheim. Consulting medical men at Nauheim were very capable in their diagnoses, and also in the administration of the bath, and the change and the quiet lazy life at Nauheim were found beneficial to a patient. When improvement set in under the Nauheim treatment it was noticed very distinctly. The suggestion which Dr. Madden made to use chloride of barium in the bath as well as chloride of calcium was a very good one. He had always had a saturated solution of the Nauheim salt to add in varying proportions to the bath, for he thought that it was important to get the water as nearly to the composition of the original spring as possible. He must say that he thought that aged patients could be treated better at home than at Nauheim, and the fatigue of a long journey was thus avoided. He treated a female patient, 81 years of age, four years ago, and she was now 85, and in full possession of her health, and had not had any return of the dilatation and

accompanying symptoms, the most severe of which was œdema of the feet. With regard to the papers of Dr. Moir and Dr. Deane, he would ask whether the safety of the Swedish exercises and of gymnastic exercises in heart disease depended upon whether the patient had been trained to avoid holding his breath? He believed that it was the closure of the glottis which brought about the danger. If a man with a diseased or dilated heart drew his breath freely the whole time of the exercise, he would not, he thought, die of the exertion. He did not think that mere pulse counting before and after the exercise told by any means all that could be told. There was much in the nervous condition of the patient. An important thing was to find out whether there was dilatation of the heart after the exercises. The dilatation would do no harm if it went down easily and quickly. But directly the heart ceased to respond to rest and to recontract spontaneously, they might depend upon it that real harm was being done.

Dr. BLACKLEY wished to echo what Dr. Nankivell had said in commendation of the papers. All the writers were past masters in their special study. Dr. Madden's reference to the occurrence of ulcerative endocarditis after influenza was a very proper one. He had had one or two cases in which the disease followed influenza, and he was glad to hear Dr. Moir suggest that the proper treatment would be to get the serum for the appropriate bacillus, whatever the cost might be. They did not know much about influenza serum. In the last case of the kind he saw, the antistreptococcus serum had been tried before he saw the patient. In this case, although the streptococci were present in the blood, the serum did no good whatever. The pneumococcus serum, if they could get it, might give more chance. He should like to ask Dr. Madden how the tracings of the heart were taken after the Nauheim treatment. He was bound to say that the more he saw of such tracings the less faith he had in them. He would be very sorry himself after mapping out a heart to his own satisfaction to go into a court of justice and swear that the heart was of such and such a size. Dr. Moir's paper on bradycardia was also a very interesting one. Probably most of them had had cases of slow pulse under their care. When he was reading hard during his student days his pulse dropped to 60, its normal rate at that time being 78. The point about the pulse of tall boys and tall men was interesting, although there had been many celebrated examples to the contrary. The great Napoleon Bonaparte was a very short man, but it was on record that he had a pulse of only 40 all his life. He had had a few cases in which patients underwent the

Nauheim treatment at home, but they were not generally very satisfactory. It was useful to get patients away from their home surroundings. One had only to go round the wards of a hospital to see that patients made much greater progress in the wards of a hospital than they would make at home. The differences between the *morale* and the general influence of the hospital and those of the home was beneficial. The point about the addition of the mother-liquor of Nauheim was a very important one.

Dr. ROBERSON DAY said that the reference to the baths at Nauheim reminded him of a patient who said that she certainly would not go to visit the baths again when she could be treated with the artificial baths at home, and she would not run again the risk which she ran upon one occasion. Psychical influences had been alluded to by Dr. Nankivell. These must always complicate observations on the pulse rate. The individual must be taken into account. The numbers which had been given were very irregular in the way in which they varied, and it seemed to be very difficult to draw any useful conclusions from them. With regard to the slow pulse in epilepsy, it was the late Dr. Moxon who said that an epileptic attack always commenced with a slow pulse. Much had been said about slow pulse in early youth and childhood. He was inclined to attach more value to the auscultatory signs than to the character of the pulse. The pulse in childhood was extremely irregular, and the irregularity could not always be estimated. Much better evidence was obtained by the stethoscope. As to deep breathing during exercise, it was a most important fact to be borne in mind, especially by those persons who engaged in athletics and mountain climbing. Mountain guides never allowed palpitation to come on, and they regulated their pace and their breathing *pari passu*. The novice who went on holding his breath came to grief sooner or later. As to the sphygmograph, he always felt that that was an instrument that people could get what they liked with. Sir William Broadbent, in his little work on the pulse, says: "The sphygmograph is not specially useful in practice, it is rarely necessary for diagnosis, and scarcely ever to be trusted in prognosis." He never forgot the occasion when Dr. Dudgeon, at a clinical demonstration, made a tracing, and then pronounced it a perfectly normal tracing. The patient in question had marked aortic regurgitation, and, *when this was known*, the characteristic tracing was easily obtained. The sphygmograph is somewhat like the camera in the hands of a skilful photographer—you can "fake" effects.

Dr. E. A. NEATBY said that he had not had any recent experi-

ence in endocarditis, but he should like to ask the opinion of members present as to whether something might not be done by using toxin instead of antitoxin. Whether the use of toxin would be isopathic or homœopathic he could not say; but whether the use of a toxin which would get as near as possible to the original toxin without actually repeating it might not be much better than using an artificially prepared antitoxin was a question worth considering.

Dr. STONHAM said that he had been much interested in the papers, and especially Dr. Madden's, because it had fallen to his lot to have to treat three cases of endocarditis which, like Dr. Madden's, had ended fatally. They all ran a prolonged course of six or eight months. The first was a woman whose heart had been damaged previously by rheumatism. The second was the case of a young man, aged 25, who had had some suppuration about a tooth which was followed some months afterwards by endocarditis. The third was the case of a woman who had had septic phlebitis, from which she seemed to recover perfectly, but in whom endocarditis occurred some twelve months after. All these were treated with various drugs, among them naja, lachesis, and arsenicum, and they were all temporarily benefited by arsenicum and the serpent poisons; but from the other drugs they got no improvement whatever, and all the drugs alike proved impotent to arrest the disease. The nosodes had never been tried, but he thought that they were well worth trying. In cases of influenza one might use influenzinum, a drug which he had used with advantage in clearing up such cases when the heart had been depressed. Another would be medorrhinum, the poison of gonorrhœa. This would be homœopathic, and it had been known to cause septic endocarditis, and possibly it would have some influence.

Dr. MIDGLEY CASH (Torquay) said that he had had very much pleasure in listening to the papers, and he never attended these meetings without wishing he was able to come oftener. With regard to the subject of ulcerative endocarditis, he had been reminded of a case which he saw many years ago when he was resident at the Royal Edinburgh Infirmary. A young puddler in the iron furnaces was brought in in a very acute state of distress. He had had rheumatism followed by pneumonia, and then he got septic fever, with sweatings, rigors, and dyspnœa. Dr. Grainger Stewart gave him (Dr. Cash) instructions that if the dyspnœa increased the pericardium was to be punctured. The pericardium was very much dilated with a

very large amount of fluid and was bulging over the heart. Things got worse, and he used a very fine aspirator needle and drew off 14 ounces of turbid serum, some pus, and blood-stained fluid, which gave great relief; but for all they could do the poor fellow died. At the *post mortem* extensive injury to the heart was found. There was aneurism of one of the aortic valve cusps which fairly peeled it off from the side of the artery, together with extensive ulcerative destruction of the whole endocardium. Such destruction as that arising in a very few days showed what a hopeless disease they had to deal with. As to Dr. Deane's paper, did not the extraordinarily rapid pulse in the recruits upon whom he experimented show that they were under an overstrain during the time of preparation?

Dr. WATKINS asked why Dr. Madden had selected the term "ulcerative," which referred to the morbid anatomy of the disease? He had seen cases in which there was no ulceration, others where there was only slight ulceration, and again, others where the granulations were so abundant as to cause a fungating appearance so that there was not only no loss of tissue present but an excess. Would not the term "malignant" be better, which at once suggested the clinical course of the disease? With regard to influenza being a cause of the disease, they had no evidence that the influenza bacillus possessed pyogenic properties, therefore the probability is that it only paved the way for the infection by the ordinary pyogenic organisms, such as staphylococci, streptococci, pneumococci, &c., which can nearly always be demonstrated to be present if sufficient blood be removed for making cultivations. With regard to Dr. Deane's paper and the subject of deep breathing, it was observed that, when persons who were no longer young ran for a train, the exertion often caused very great distress when the destination is arrived at; but if at once they got into the train and took deep breathings for two or three minutes, the distress rapidly subsided.

Dr. JAGIELSKI said that they had heard much about active exercise, but they had not heard anything about passive exercise. It appeared from his experience that passive exercise, such as massage, had a wonderful effect upon the circulation and upon the pulse, and this was a form of exercise which every medical man who occupied himself with the subject would see the importance of. At the end of a few months the pulse would alter, and the weak pulse would become much stronger and, at the same time, much steadier. When a man had heart weakness naturally, or a dilated heart, that must be taken into consideration. Dr. Deane,

in giving an account of his observations, had not said anything about the temperature at which the exercises were taken. A warm climate and a cold climate were different conditions which very greatly influenced the action of the heart and the pulse. All that appeared to have been forgotten. The pulse grew weaker in hot weather. A very interesting point also was the improved and super-breathing after prolonged singing exercises and a better heart's action, so that Italian singers and, in fact, all those persons who exercised themselves in singing, underwent a wonderful improvement in their general health through breathing in an artistic way.

Dr. GRANVILLE HEY said that Dr. Moir had spoken of the use of collargol. Recently, in Vienna, he had an opportunity of seeing collargol used on a large scale. Septic cases were not uncommon there, such as septic phlebitis after abdominal and pelvic operations. The collargol was injected intravenously once a day, and in several cases patients almost moribund picked up very rapidly and were discharged in a healthy condition. There were some failures, but he did not think that in all of them death was due to the supposed condition of the veins. In one of the cases, although the patient lingered for a few weeks, the temperature chart and the appearance of the patient simulated much more a tuberculous condition than a septic condition. He was surprised at the results obtained from the injection of collargol into the veins, in cases of septic phlebitis, and thought it might prove useful in cases of ulcerative endocarditis, if its use were persisted in for some time.

Dr. MADDEN, in reply, thanked the meeting for the way in which his paper had been received. He thought that the most promising suggestion with regard to treating this form of endocarditis was that made by Dr. Neathby and Dr. Stonham, which was that they should endeavour to get at the toxin of the most probable origin of each case and use that as a remedy. He thought that that might give very considerable help, and he hoped the suggestion might be worked upon. With regard to the Nauheim treatment, Dr. Blackley had asked the way in which the tracings were taken. He (Dr. Madden) always had the patient lying flat on his back, and he checked the first result by using the stethoscope, but he seldom had to correct his first marks. When the tracings were taken by the double method they were not likely to contain any great mistake. He was interested to hear Dr. Blackley say that, though he thought cases would do better at Nauheim, still he got very excellent results at home. His (Dr. Madden's) results had been sufficiently good to induce

him to treat cases at home. The answer to Dr. Watkins' question, why he had called the disease "ulcerative endocarditis," was that he (Dr. Madden) had simply taken the first name which occurred in the text-book on the subject. Various names were given. No doubt "malignant" would be more correct pathologically. He was extremely interested in the question of deep breathing and its effect on the heart. It was not possible to make the same effort with the breathing going on deeply all the time as when the breath was held, though no doubt the holding of the breath put a great strain upon the heart. Any person could try this for himself. A great effort made with the breath held caused the pulse to go up, because of the temporary dilatation of the heart. He believed that the epigastric pulsation was almost necessarily accompanied with, and probably caused by, excessive though usually temporary dilatation of the right side of the heart.

Dr. BYRES MOIR remarked that Dr. Roberson Day appeared to him to be quite wrong in what he had said with regard to the sphygmograph. He (Dr. Moir) believed that anybody who had worked carefully with the sphygmograph would find it a great help in practice. It showed when failure was taking place, and it confirmed results which could be kept for reference.

Dr. DEANE said that Dr. Madden was quite right in what he had said about the breathing during the exercises. To do most exercises and breathe deeply at the same time was practically impossible and unnecessary. He had sent a trained gymnastic instructor up a slanting ladder, telling him to breathe deeply all the time, and at the end the man was giddy. It was good to draw a few deep breaths after exercise, but expiration must be as free as inspiration. But the influence of deep breathing on exercises, generally of various sorts, needed much investigation.

THE HOMŒOPATHIC DOSE QUESTION.¹

BY R. GORDON SMITH, M.B., C.M.ABERD.

Honorary Medical Officer to the Hahnemann Hospital, Liverpool.

MR. PRESIDENT AND GENTLEMEN,—Towards the close of our last session I had the honour of reading in your hearing some remarks in which reference was made to that much-disputed question, the homœopathic dose. And

¹ Read before the Liverpool Branch, December 14, 1905.

whether my remarks were so dark, muddy, and obscure that you could not see through them I know not, but you were good enough to give me another chance, and asked me to bring the subject before you again on a future occasion, which occasion seems now to have arrived.

But I am sorry to say that I cannot throw much more light on the subject *now* than I was able to then, which, I am painfully conscious, was exceedingly little. However, I hope that during the discussion, which will come on in due course, some of the members will be able to dissipate the darkness in which the dose question up to now has been enshrouded, and settle it once for all to the entire satisfaction of the whole homœopathic body.

Now, this question, to us as homœopaths, is one of great interest and vast importance, and does not lend itself to being put in a nutshell. It is a large question and bristles with points, giving ample scope for wide differences of opinion.

It was the question of the dose which raised the most bitter animosity and antagonism to the founder of homœopathy among his medical contemporaries. And the homœopathic dose has been the butt of many cheap jokes, and the subject of much ridicule, in what I suppose we may still, with a measure of truthfulness, call the opposition camp. The expression of their feelings towards it has varied with circumstances, for while at times they have laughed it to scorn, at other times it has roused their bitterest indignation, and they have given to it their whole-hearted malediction, and with a vehemence which it is quite unnecessary for us to attempt to excel, or even to emulate.

And among members of the homœopathic body themselves it has been argued about, written about, and almost quarrelled about many times since Hahnemann made known his new principle to the medical world of his day.

Now, the homœopathic dose, a very minute and harmless quantity, has a little history of its own. Of course, we have all heard that Hahnemann began his homœopathic campaign with the *usual* doses, a statement rather indefinite to be satisfactory, and one is a little curious to know just what

these *usual* doses were. And, in order to gratify my own curiosity, I looked into "Ameke's History of Homœopathy" to see if there was any light thrown upon these *usual* doses. And, if we are to take him as an authority, the Hahnemannian dose was anything but infinitesimal to begin with.

For example, he recommends that 5 to 50 grs. of crude powdered antimony should be taken daily in order to purify the blood, whatever may be the true meaning of that phrase (1784).

He also says that good results can only be expected from *conium maculatum*, if given in sufficient doses to produce some degree of giddiness, and a feeling as if the eyes were being pushed out of the head, nausea, and trembling of the whole body, with loose evacuations from the bowels. Surely evidence sufficient that a full dose has been administered. (This in 1787.)

Then, 12 to 15 grs. of the powdered leaves and root of *belladonna*. And he naively remarks that some degree of giddiness should follow the use of this powerful drug, if any beneficial result can be expected to follow. And $1\frac{1}{2}$ to $2\frac{1}{2}$ ozs. of powdered *cinchona* bark to be given daily for what is called "nervous fever." And in what the "Ameke History" calls "epidemic fever," he recommends 15 grs. of camphor to be given daily. But he adds, he soon found that he had to increase the dose to 30 and even 40 grs. daily, if he wished to produce rapid amelioration. (This in 1798.) Two years after, the *new principle* was made known to the world through the medium of *Hufeland's Journal*.

If these were the *usual* doses with which Hahnemann set out on his homœopathic career, one can imagine the most rabid advocate of the full dose accounting him as a brother beloved at this stage of his history. And whether these doses tell of Hahnemann drunk, and sniffing at a phial containing one globule of the thirtieth dilution tells us of Hahnemann in his sober senses, I am not prepared to say. But it was the same Samuel Hahnemann who recommends both. And we must give him credit for having travelled from pole to pole of medical posology.

However, there is this to be noticed at this early stage of Hahnemann's career as a homœopath. He has got down to simples. There are no mixtures, not even alternation. He prescribes one drug, in a somewhat heroic dose if you like, but only one drug at a time; no more.

But we must remember that the change of mental attitude towards the dose did not occur *per saltem*. Years passed while he was changing from the one standpoint to the other. And while the change was gradually taking place, he and the noble few who were daring enough to follow him, and avow themselves his adherents, were experimenting with drugs upon themselves and members of their families, and, all the while, were being persecuted and maligned with such vehemence and virulence as would have turned to gall and wormwood the spirit of most men, and transformed them into cynics.

Gentlemen, Hahnemann and his contemporaries were grand fellows. We will not claim for him that he was the discoverer of homœopathy, there were hints and inklings of it long before his day. But he did formulate that law which guides us in forty-nine-fiftieths of our daily work. And he and they together have bequeathed to us a wealth of pathogenetic material, setting forth the effects of drugs on the healthy, with a minuteness and precision, such as had never before been attempted, and has had no equal since. So, while it is not necessary for us to bow the knee and worship this "Grand Old Man" of medicine, let us refrain from being detractors of him, or of those who were his collaborators.

Now, that law by which we profess to be guided in our attempts to cure the sick by drug administration, and expressed in the formula "*Similia similibus curantur*," *applies solely and alone to the action of drugs*. True, Hahnemann sets forth clearly enough in the "Organon," that it is the obvious duty of the physician to carefully examine, and take into account when selecting a remedy for his patient, the predisposing and exciting causes of disease. The temperament, habits, occupation, domestic relationships, and age, &c., and all with a view to aid him in selecting a remedy for the case in hand. But the law as set forth

in the formula takes no cognisance of anything but drug action ; it has nothing to say about doses, large or small, full or infinitesimal. And as for diseased anatomy, or what in our day is called *pathology*, Hahnemann's soul abhorred it, and, from his therapeutic standpoint, he would have nothing to do with such a thing.

Now, this law or formula, to which we have given our adhesion, demands that the pathogenetic effects of the drug to be employed shall be similar to the symptoms presented by the case to be treated, and the greater the similarity between the two so much the better. In short, the *similimum*, find *that* if you can.

And while we are talking about similarity, we must have *two* objects to be similar one to the other ; or two pictures, one to be a likeness of the other. The patient presents to us one picture, namely, that of his disordered physiology, in other words, his disease. Having examined this picture in all its details, and carefully noted its features and peculiarities, the next thing to be done is to repair to our gallery of *Materia Medica*, and there look for another picture, the *most like* we can find to the one we have just examined, namely, the sick man or woman.

Suppose we have been fortunate enough to find a picture which answers in the great majority of its pathogenetic features to the picture presented by the patient. Placing them in juxtaposition, our expectation and desire is that one of our pictures, namely, that presented by the patient, shall in due course become blurred, obscured, and ultimately completely blotted out, so that he shall have no pathological features, abnormal physiology, or disease symptoms to show, but will again be a whole or healthy man. All this we hope will be accomplished by the application of our law, *similia similibus curantur*.

Now, while we have been talking about pictures and a picture gallery, we are still dealing with drugs and patients. And having found the like drug, how *much* of this *like* drug are we to give the sick man to cure, and make him well ? Or shall I say how *little* will be sufficient to accomplish the object in view ?

I take it for granted we all admit, that if we give him sufficient to produce physiological effects we shall only add to his trouble, and between disease and drug effects combined he might sink and die; and none of us wish to be a party to the furtherance of such a result as that.

Then we say we must reduce the dose, making it less than would be capable of producing physiological effects, *but reduce it by how much?* That is where the dose question begins to pinch, for "*tot homines, tot sententiæ.*"

There are members of the homœopathic body who in effect say, how *much* may I give my patient short of producing injurious effects? There are others who say in effect, how *little* may I give with any hope of producing the result I wish to see brought about in this case? And the two parties are as wide asunder as the poles; the one party being the conservatives and the other the radicals of homœopathy. And between the two extremes there is a third party which we might call the *moderates*, to which I think the great majority of British homœopathists belong.

Some move along as closely as possible to the water-mark on that shore washed by the physiological dose, giving ϕ tinctures and 1x dilutions in five- and ten-drop doses. And only when giving these doses do they feel that they are giving something in the shape of medicine which ought to produce undoubted results. And far from these doses they do not feel that they can go with safety.

Others, somewhat more venturesome and daring spirits, give 6ths, 12ths, 30ths, and upon occasion the 200th, and claim results in practice equal, if not better, than the man of the more massive dose. But for high dilution, the man of the 200th potency is nowhere, he is still among the crudities of posology. For we have brethren who are not happy till they get to the 10,000th, and even then they are not quite at home, they deem the 100,000th a good point to start from, and hence onwards to anything you like. But they are all honourable men. And at the same time I am satisfied in my own mind that the 100,000th potency or dilution made according to, and by, the Hahnemannian method has never yet been seen

on our planet, and probably never will be seen. And if it should some day make its appearance, some one will have spent much time over its preparation which might have been employed to better purpose.

Now, we have seen that in the early part of his career Hahnemann gave the so-called *usual* doses which were anything but infinitesimal. But the whirligig of time went round as it has a knack of doing, and we find the man who at one stage of his history recommending 5 to 50 grs. of crude powdered antimony daily, writing to one of his disciples as follows: "I do not approve of your dynamising medicines higher than, for instance, the 12th and 30th, there must be some end to the thing, it cannot go on to infinity. By laying down, as a rule, that all homœopathic medicines be diluted and dynamised up to the 30th dilution, we have a uniform mode of procedure in the treatment of all homœopathists, and when they describe a cure we can repeat it, as they and we operate with the same tools. Then our enemies will not be able to reproach us with having nothing fixed; no normal standard."

Tell it not in Gath, but here I dare to disagree with and differ from the master. A uniform dose would be the easiest thing possible to attain. But whether uniform results would follow the administration of this uniform dose "I hae ma doots." To begin with, there is no pathogenetic or physiological dose that will produce uniform results on, say a dozen, different individuals. For example, were you to begin proving a drug, and were it possible for the time being to place all your provers in the same conditions as to hygiene, or as it is now called, under the same environment, and were you to give each prover the same quantity of drug per dose, and the same number of doses per day; if the proving be carried on for, say, a month, would it be likely that you would come out with uniform results at the end of that time? Probably in no two cases will uniform results be obtained or anything approaching uniformity. Each prover's book will tell its own story, but in all probability no two of them will tell the same story from first to last. And all this from varying susceptibility to drug effects and individual peculiarities and idiosyncrasies.

Now, patients retain these varying susceptibilities and peculiarities in disease as in health, and although we have good reason for believing that the whole physiological mechanism of the body is excited and rendered more sensitive during the presence and pressure of acute disease, we have no warrant for saying or believing that disease, whether it be acute or chronic, will reduce all patients to a state of pathological equilibrium, in which they will all be affected to exactly the same extent and in exactly the same way, by a uniform dose of medicine, of a uniform strength or dilution.

Hence, for my own part I do not believe that there is *one* uniform or standard dose that would be the best *possible* for *all* patients, under *all* circumstances, even if they were *all* suffering from the same disease. But which requires the more, and which will be sufficiently affected by the less, is a question which, for the present, awaits a satisfactory answer.

Suppose we were to transfer the argument for a uniform dose of medicine elsewhere, say to the question of food or sleep, how would it apply? As to food not at all, either as to quantity or quality. We all know men, and women too, who consume twice as much food as others who live under very much the same conditions as to labour and general environment, and yet they may be looked upon as belonging to the lean kine herd. And also, we all know the homely proverb about one man's meat being another man's poison, and it is quite true. Nature has so many moulds into which she runs her specimens of humanity, that no two of them are alike mentally or physically. In fact, she breaks to pieces every mould she uses, so that it shall never be used again ; she delights in variety.

Once in a while she gives us a Galileo, an Isaac Newton, a Hahnemann, a Faraday, and a Becquerel, endowing them with an intellectual equipment which enables them to tower above their contemporaries and write their names large on their own and all coming ages. Again, she sends others into the world with scarce enough mental capacity to tell them to seek a shelter when it rains. She makes bodies

large and small, minds the same, and puts the capacious mind into the little man physically, and *vice versa*, but always endless variety.

In the midst of all this mingled mass of variation and diversity, how can we imagine, or believe, that one uniform dose of medicine, or anything else for that matter, will produce uniform effects either as to degree or kind? And whether the true inwardness of all these types and variations will ever be fathomed or understood, I know not, but for the present it looks as if we would have to go on with approximations to the best.

Now, our patients being men and women, each has his and her own peculiarities and characteristics, one having a greater susceptibility to drug action than another. And some will have a greater susceptibility to the action of one drug rather than to the action of another. The skein looks tangled enough from the patient's side of the equation. And as if that were not enough, is there no variety in the vegetable kingdom from which we obtain so many of our most potent medicines? Seeing that they grow wild under widely different climatic conditions and out of many different varieties of soil, are their medicinal properties to be relied on as being always the same? I fear not. The practice of homœopathy is not exactly a pastime, and *still* it is the only method of drug administration in vogue at the present time that has the shadow of a scientific basis to rest its foot upon.

No doubt the dose question has been a great, if not the chief, obstacle to the spread of the system among the general body of the profession. Probably it has warned off, and kept back more from looking into and investigating the subject than anything else connected with the homœopathic method of drug administration. And so far as I can gather it has been a much more potent cause of mental perturbation to our predecessors than it seems to be to us of the present day. They had to defend their position much more strenuously than we of the present are called upon to do. We are not dragged into the law courts when a patient dies, and charged with malpractice, as were some

of them, even in this country, and frequently enough on the Continent.

Our brethren over the hedge are not throwing mud at or molesting us in any way. We are having a quiet enough time, and are being allowed to work out the salvation of homœopathy, if we like and care to do so.

However, we seem to have arrived at that rest-and-be-thankful stage and state of mind, which is for us *bad*, seeing so much remains to be done. If heaven would only send us *another* man of like mind with old Samuel Hahnemann, who would stir us up and out of our lethargy, and set us to do something in the way of perfecting our *Materia Medica*, it would be a boon to homœopathy, and the world at large. I fear there have been but few well-proved drugs added to our *Materia Medica* during recent years, *that is*, proved as Hahnemann and his contemporaries used to prove them, and not much done in the way of reproofing either. Our brethren on the other side of the pond say that the only unaddled egg the British homœopathic hen ever laid was *kali bich.*, and she has never ceased to cackle over it since. So we are left to suppose she has not had time to lay another for cackling over her last production.

Well, it is a pity, but we have not a monopoly of the addled egg business. They have exported to this side quite as many of that kind as we want. But for *gelsem.*, *lachesis*, and all such, we thank them most cordially.

It is just here that homœopathy requires, and urgently demands, the assistance of her adherents. A reliable *Materia Medica* is the great desideratum for her now and always. I care not how numerous the symptoms ranged under a drug may be, but do let us have them reliable. But much remains to be done before we have a *Materia Medica* to which we can truthfully apply the term *reliable*.

Now, as to a *law* for the dose, much has been said in discussions and written in our journals on this point from time to time. The late Dr. Yeldham advocated that the dose should be *just short* of producing the physiological action of the drug, and no less. But he was met by the argument from some of his contemporaries, that they had

seen undoubted pathogenetic effects produced from attenuations *very* far removed from the physiological dose. The late Dr. Bayes, I think it was, claimed to have witnessed pathogenetic effects produced by the 30th of sulphur.

The late Dr. Black made a bold stand for limiting the attenuation of the dose to the 3rd dilution. Not that he maintained that the higher attenuations were useless or inert, but that they were unnecessary for therapeutic purposes, as all the best and most potent action of the drug lay between the mother tincture and the third centesimal dilution. And that if exceptional cases occurred requiring higher attenuations, they were so few and far between that they might be considered almost a negligible quantity. Had Dr. Black been able to impress his brethren with his ideas, it would have simplified matters very much, but the voice of opposition was again raised and the contest went on as before between, shall we say, the *wee threes*, and the 200th and higher men. We seem to be enjoying a period of quiescence from the dose question at present, but it will come up again as surely as there is a dose question to be settled.

I might mention one gentleman whose method of dealing with the subject was both original and simple. Dr. Cruant, from Mataro, in Spain, laid his short and easy method of settling the matter before the Hahnemannian Society of Paris. His method of procedure was as follows: Were the disease one day old he gave the first dilution, if two days old, the 2nd; if three days old, the 3rd; and if a year old, the same principle being carried out, the 365th had to be brought into requisition. But with all its simplicity it did not win the approbation of the homœopathic body; the reason why need not be stated.

Now, after all this, what is there to be said for the dilution or potentisation of drugs? To my thinking, there is much to be said for the process. Although I am not in love with the words *potentise* or *potentisation*, still these words have found their way into our literature, and in it, no doubt, they will remain. But the words seem to convey the idea of imparting to the potentised substance a power or

energy which it did not possess, previous to the process of potentisation. I do not know how many of us would be prepared to accept this as a result of triturating an insoluble substance with sugar of milk.

By the process of trituration there may be, and to me it seems there *must* be, a liberation of potential, inherent in the substance, previous to the process of trituration being performed. But it would be a mere assumption, were we to assert that the process of trituration had *imparted* to the substance triturated a power or energy which was not inherent in it before, and always.

When we think of such substances as aurum, argent met., calc. carb., carbo veg., merc., nat. mur., sepia, silicea, and many others that might be named, we are not aware that in the crude condition any one of these bodies is possessed of any therapeutic action whatever. But being triturated—potentised, if you prefer it—away from the crude condition, to a greater or less extent, they become most efficient therapeutic agents, which we use every day with satisfaction to ourselves and benefit to our patients.

I think it must be admitted that experiments, or provings, made with these insoluble substances, after dilution or potentisation, have brought out a host of symptoms, and very reliable symptoms too, which would never have become known to us, but for provings conducted with drugs, and especially the insolubles, when in a more or less dilute condition. In fact, almost all substances from the inorganic world were not medicaments at all, until they underwent the process of trituration and dilution.

At the same time, trituration, if it be to produce its full and legitimate effects, is an operation requiring to be conducted with the greatest care. The whole subject of trituration was gone into about twenty-five years ago by Drs. Conrad Wesselhoeft, Meyerhofer, and Buchman. And when they published their results, there was much heart-searching in homœopathic circles, for the results of triturating insoluble substances with sugar of milk were not so satisfying as had previously been supposed. Drs. Edwards Smith, Deschere and S. A. Jones attempted

to check the experiments, but in the end they arrived at pretty much the same conclusions as the three original experimenters.

Soon after this, a new edition of the "British Homœopathic Pharmacopœia" was issued, and this concession was made: that all triturations should be begun on the decimal scale, instead of the centesimal, and, moreover, that equal parts of the drug and sugar of milk should be triturated for part of the time, gradually adding the remainder of the vehicle.

But when all is said for trituration that can be said, the concurrent opinion of all observers, who have investigated the subject with anything approaching thoroughness, amounts to this, that about one-third of the insoluble drug undergoes nothing more than a coarse comminution. That the greater part of the subdivision of particles has been arrived at during the first stage of the process, and in subsequent attenuations, there is a progressive diminution in the number of drug particles, but not in their size. Hence trituration is not a subject on which the homœopath can rest his weary head with very much comfort.

But, gentlemen, after the microscopist and the chemist have said their last word, there is still the clinical test, and it will ultimately carry; for the dose question will never be settled by the microscope, nor the test tube, not even by spectrum analysis. Any one wishing to follow up this part of the subject will find triturations pretty fully discussed in the *British Journal of Homœopathy*, vol. xxxviii., and dilutions in vol. xxxix.

Now, our dilutions of insoluble substances are made from these same apparently unreliable triturations. But who among us would like to be deprived of the use of calc. carb. 6th, 12th, and on occasion the 30th, and some would say the 200th. I for one would not. Although I am not wedded to the high dilutions, and have had comparatively little personal experience with them, there *are* those who can speak with authority regarding the potency of the higher dilutions. I refer to such men as Stapf, Boeninghausen, Aegidi, Hering, Dunham, Lippe, Farring-

ton, and a host of others, who have won for themselves a name and a place in the foremost rank of the homœopathic body. These all died in the faith of the higher dilutions, after having used them during a considerable part of their lives. And these men were hardly what you would call dreamers, but as hard-headed and logical as men are made. They have all written on subjects connected with homœopathy, and any one who takes the trouble to read, say, Carrol Dunham's works, will not go far, or dip very deeply into them, before coming to the conclusion that his was a mind possessing a vast store of medical knowledge, and of the collateral sciences as well. And when men of that stamp tell us, that in their experience, the higher dilutions were superior to the lower and lowest, we can hardly set aside their testimony as worthless. So you see, gentlemen, we have with us still the low, the high, and the medium dilutionists, and the final settlement of the dose question is not with us just yet.

But we know how we got hold of the pathogenetic material we possess, which is both our glory and our shame. There is nothing in the whole range of medical literature like it for goodness: and it is not nearly so good as it ought to be, and as it might be. It was got together as the result of experiment, long and carefully conducted. And I do not see that anything else, or less, than long and carefully conducted experiment will do much for us toward the settlement of this question. It has been written about, and talked about, more than enough, and what is wanted now is carefully conducted experiment, and it will require to *be carefully* conducted if any good is to result from it. And if the results of experiment tell us, and tell us again, and again, and again, that the 10,000th, or the 100,000th for that matter, is better than the ϕ tincture or the 1x, I would like to have a mind sufficiently open to accept these results, however much they might clash with hitherto held conceptions and opinions.

But there is this to be said, the onward march of science is with homœopathy, and with us as its adherents. In all departments, every step she takes in advance tends to bring

into greater prominence the power and potency of the infinitesimal throughout the whole domain of Nature.

We all believed at one time, that with the atom we had reached finality in the direction of the divisibility of matter. But much has happened since then. Electrons, ions, and corpuscles have been discovered, which transform our infinitesimals into immense crudities. For example, the atom of hydrogen, which as you know has one or unity for its atomic weight, that atom is now believed to contain as many as a thousand corpuscles. In other words, there are particles of matter one thousand times smaller than were believed to exist a dozen years ago. And the *power* of them. The heat evolved by exploding a volume of oxygen and hydrogen, mixed in the proportions required to form water, is about two calories. But the heat evolved by the rupture of the radium atom and the rearrangement of its corpuscles is calculated to be over three million five hundred thousand times greater than that let loose by any known chemical reaction. And the number of these radio-active bodies is being added to month by month; and who knows where it will end? And the remarkable thing about them is that the farther down we go among these infinitesimals, the more potent they seem to become, each being what might be called a Pigmy Hercules.

So there is still hope for infinitesimals, and much of it. In fact, it seems to be coming to this, that infinitesimals are doing the great bulk of the work of the world.

And in disease, too, they are wielding a mighty power. We are only beginning to know and realise how much and far-reaching their influence is here. Among our allopathic brethren, some of whom are inclined to bestow on us a beneficent smile of pity, because of our dose delusion, are also believers in infinitesimals, for they are giving their days to hunting for microbes, organisms so infinitesimal, that it is absolutely necessary to use a twelfth immersion lens to establish their existence. And all this hunting, because, to the presence of the microbe, infinitesimal though it be, is to be attributed some malady, which will in due course demolish, and lay in ruins its host—the human organism.

So it comes out incidentally, that they too have a profound faith in infinitesimals, and rightly so; they may not be, indeed *they are not*, the infinitesimals with which we are most concerned, but still all the same, infinitesimals.

And as years roll on, we all shall have to believe in infinitesimals with a larger faith than we have been called upon to exercise toward them in the past. Gentlemen, I have wished to make out a good case for infinitesimals, my homœopathic bias tends to sway me in that direction. The homœopathy of Hahnemann was the first dip into the region of infinitesimals, and now all science is falling into line.

Now, with all the uncertainty by which we are surrounded, triturations unsatisfactory, and dilutions, too, for that matter, it is a wonder we get along as well as we do. We give a person a comparatively small dose of medicine, which immediately comes in contact with a tongue coated with all sorts of *débris* and microbes; later, if it finds its way into the stomach, it lands in a perfect cesspool there, and meets with gases, acid fluids, and a host of chemical properties, and principles: what chance has it? We give more or less strict directions as to diet, hygienic and sanitary arrangements, which in a goodly number of cases are scrupulously disregarded. And if we *prohibit* anything in the way of food or drink, these were just the things the patient was inclined to take, and so the patient has had them, as we learn on our next visit. Again, I say it is a wonder we get along as well as we do.

On the last occasion, I ventured to give some advice to my junior colleagues in reference to the study of the *Materia Medica*, that advice I would again reiterate. I am quite prepared to admit that the *Materia Medica* does not read like a modern novel or romance. Yea more, I am prepared to admit that drug pathogenesis was to me, to begin with, the most forbidding and uncouth form of literature I ever tried to get a nodding acquaintance with. But, gentlemen, if you are to be homœopathic physicians, you *must* make its acquaintance, and the more intimate and close your acquaintance is with drug pathogenesis, the greater will be your success.

Let me advise you, however, to leave Allen's ten volumes and the "Organon" on one side to begin with. Master the Primer first. We were all at the primer stage in everything once, and in your first efforts to master the *Materia Medica*, you will find it better to go back to the primer again. Because it is not a subject which opens the doors into its deepest and darkest recesses at the first lesson you take. The mind has to grow into the subject, and the subject into the mind, and as you know, all growth is gradual! But in due course, light will break in upon what to you as beginners seems impenetrable darkness, and order will arise out of what appears to be chaos come again. And as the day breaks, and the darkness fades before it, which it will do (but not all at once), you will become more and more interested in the subject of your study, and in fact, you may become so enamoured of it, that in time it may become your favourite work. And now is the time to begin; for the subject is large, and demands persistent application. Like gold of the mine, it has to be laboriously worked for, before it becomes the current coin of the realm. But having acquired the knowledge, it will go a long way toward helping you to find the *similimum* for your cases. And having found that, and administered it, I believe you will have done the best any physician can do for his patient. The *similimum* will help your patient back to health, and you to success.

A CASE OF FLATULENCE, WITH REMARKS.¹

BY T. G. STONHAM, M.D.LOND., M.R.C.S.ENG.

THE case I am bringing before the Society this evening was for a time an inmate of this hospital and underwent both surgical and medical treatment without deriving any appreciable benefit. She came under the observation of

¹ Presented to the Section of *Materia Medica* and Therapeutics, January 4, 1906.

many here present, and her case was a remarkable one both from the nature of its symptoms and from the manner in which they were ultimately cured. It will therefore, I think, be of interest to the members of this Society and may serve to introduce points in pathology and therapeutics worthy of discussion.

Mrs. R., now a middle-aged woman, but not past the climacteric, although vaccinated when a baby, had an attack of small-pox when between 8 and 9 years old. She has not been vaccinated again. The small-pox left scarcely any traces on the skin, and her general health was good until she was married. Soon after marriage she began to suffer from menorrhagia, and a year after she went into the Samaritan hospital and was curetted. This operation was followed by peritonitis, and she remained very ill for a long time. At last she went to Dr. Allinson, who put her on a semi-starvation diet and directed her to bathe the abdomen daily with ice-cold water, promising that she would be well at the end of six months. She followed out his instructions, and before the six months had elapsed she was well. She continued well, but never became pregnant. About ten years ago she had an attack of influenza, and during the convalescence from that she got a wetting and took a chill, which started the long train of troubles which I now relate.

The illness commenced with pain in the abdomen and swelling. She consulted Dr. Neatby, who placed her under my care. When I saw her the abdomen was swollen, dull in both flanks, with fluid percussion wave; there was some rise in pulse and temperature, and a feeling of a hard lump, which was tender to pressure, between the umbilicus and the left lower ribs. It was diagnosed as a case of tubercular peritonitis. She was in bed many weeks, but under treatment, which, as far as drugs were concerned, consisted principally of iodide of arsenic. She ultimately made a good recovery, but the abdomen was left enlarged though not dropsical, and there remained an ill-defined, resistant mass between the umbilicus and the left lower ribs.

I saw no more of her for three years, during which she had got on fairly comfortably, but had not been able to do much work, and had had pain and tenderness in the abdomen, at times necessitating a few days' lying up. On November 23, 1898, she came complaining of a constant slightly tinged discharge from the vagina, which had lasted for five weeks, and on the last two days had been bright like an ordinary "period." She was given arsen.

iod. 3x. night and morning, and sulphur 6, m v., ter die. Normal menstruation came on and lasted a week, during which there was much abdominal pain, sharp and cutting, diminished by lying on the back; on turning over on to the right side something heavy seemed to fall over from the left side and caused pain. Menstruation ceased at the end of a week, but sharp cutting pains continued round the navel and in the position of the transverse colon. Bryonia caused improvement, but at the next menstrual period the discharge continued for twenty-four days, and was considerable in quantity. It was accompanied by sharp shooting pains just inside the vagina, and an aching pain over the sacrum, and also by a looseness of the bowels, which were opened after nearly every meal. This last symptom was stopped by aloes 3x, m v., night and morning. The iodide of arsenic was resumed. The vaginal loss soon ceased, and the patient became better.

In March, she had some abdominal pain and tenderness, and a profuse menstruation. I may mention here that there were no physical signs of any consequence discoverable in the pelvis other than a somewhat enlarged uterus which was in a normal position. She also had dyspeptic symptoms, drowsiness after meals and rumbling and gurgling in the bowels, but under pulsatilla 3x and then strychn. phos. $\frac{1}{800}$, she got better and remained well for the following eight months, till November, when she came complaining of diarrhoea, distension after meals, eructations and passage of flatus and sinking sensations, as if about to faint, which came over her several times a day, starting from the stomach and going up to the head; she retches with them and feels cold, but never loses consciousness and never vomits. On examining the abdomen I found it much softer than it used to be; the transverse colon was distended and filled with wind and fluid which gurgled beneath the hand. The hardness that used to be above and to the left of the umbilicus was gone, but there was tenderness to pressure over the splenic flexure of the colon. She passed a large quantity of colourless urine. She was given china ϕ , followed in a few days by aloes 3x, under which many of the symptoms, and notably the diarrhoea, improved; but some more distinctly nervous symptoms supervened, such as sleeplessness and terrifying dreams of being buried alive, from which she woke up screaming; and a continuance of the passage of much colourless urine. Of late months the catamenia had become scanty, and on the last occasion there was a three months' interval. She was given lachesis 12 t.d.s., and was soon much better and remained so for six months, till July, when another similar train of symptoms appeared, which

in a few weeks gave way to lachesis and sepia. In January and February, 1901, she had an attack with dyspeptic symptoms, much flatulence, which was freely passed, and an aching pain across the sacrum, which got better under sepia, and in July, 1901, a similar attack, with looseness of the bowels. Otherwise, she remained fairly well till January, 1902, when she began to suffer again with much soreness and pain in the abdomen, and an increase of flatulence, chiefly in the left hypochondrium. This continued through February and March, and on March 13, during a monthly period, which was scanty, the pain increased suddenly, and became general all over the abdomen, and for the first time was accompanied by vomiting of scanty fluid, thin, yellow and bitter. The abdomen was found distended, there was resistance and hardness below and to the left of the umbilicus, dulness in the left flank, tympanites elsewhere. Abdomen measured $27\frac{1}{2}$ inches round the umbilicus. She was kept in bed a month and treated in turns with ars., iod., lycopod., and sepia. There was constipation, the stools being scanty and hard. She gradually got better and was able to go away to the seaside. At this juncture, in answer to questionings she told me that she had had a bad fall on her stomach when a child, and she was consequently given some arnica 30 night and morning for a time. She continued to improve, though she remained on and off under treatment for the rest of the year; but the following year, 1903, she remained well, and nothing more was heard of her till April, 1904. On April 29, during my absence from practice on account of illness, Dr. Day kindly saw her for me in answer to an urgent summons. He found her in great pain, with enormous abdominal distension, and vomiting at frequent intervals. She thought she had caught a cold seven weeks before, but had got about for the first four weeks. She then took a purge, which made her worse and started the vomiting. She then had to go to bed, where she had been for three weeks, getting worse. Dr. Day advised her early removal to the London Homœopathic Hospital, where she was admitted under Dr. Blackley on April 29, to whom I am indebted for permission to use the notes of the case. She was kept under observation for a fortnight. On examination there was found much gurgling in the colon and sigmoid flexure, and on the left side the lower end of the kidney was felt and was tender on palpitation. There was a trace of albumen in the urine. Lycopodium was prescribed, and later on coloc. and cham., but as no improvement occurred, a consultation was held, and an examination of the patient made under an anæsthetic, May 16. Several who were

present at the examination expressed the opinion that there was a cyst. Dr. Neatby found the uterus forward, but displaced to the right; on the left of the uterus a cyst the size of an orange in the broad ligament or in Douglas' pouch (?), connected with the swelling in the abdomen. It was decided to make an exploratory incision, and on the next day (May 17) this was done by Mr. Knox-Shaw. The peritoneal cavity was found closed by adhesions. The swelling noticed before the operation was found to be coils of intestines matted together with fibrinous adhesions which could be fairly easily separated, but separation was followed by hæmorrhage. Some of the adhesions were so firm they could not be broken down. The mesentery was thickened in places, and enlarged glands could be felt. In spots were yellow-coloured hard tubercles. The part in the pelvis could not be isolated owing to the adhesions. The wound was closed with interrupted silk-worm gut suture.

The patient made a good recovery from the operation. On May 25 she was sent back to the medical wards, and the house physician notes: "Still griping pains in the abdomen, which seem as bad as ever. Patient evidently not at all improved by the operation." On the 30th there is a note: "The night before last, after a dose of cham., she felt something snap inside and was then able to lie on her side for the first time." The pain, however, did not materially lessen. On June 10 she had to have a morphia suppository, and later on in the month hypodermics of morphia were given. Iodine vasogen was rubbed into the abdomen, and chamomilla was found to relieve occasionally, but most good resulted from the administration of silica 30, which was commenced on June 30, and from which time improvement took place, so that on July 15 she was discharged. The temperature had been normal or subnormal during the whole of the time she had been in the hospital, except for a trifling rise for a day or two after the operation.

Dr. Watkins reported on a nodule taken from the peritoneum during the exploratory operation, that it "consists of adipose tissue and well-formed connective tissue. No appearance of new growth present."

After leaving the hospital at the end of July she was at home for about a month and got on fairly well. She was wheeled out to Parliament Hill every evening, and even got to the length of walking a few spaces. She then went to the Royal Sea-bathing Infirmary at Margate, but was sent back after a week as an unfit patient. She says she was never warm there, and was not strong

enough to keep about all day, as was expected of her. She felt much worse on her return than before she went. Sickness and pain came on again, and she was readmitted to the hospital, and was again given silica 30 and iodoform vasogen rubbed into the abdomen. From September 26 to 30 an attack of diarrhoea occurred with relief to pain, and on October 13 and 14 there was repeated vomiting, on the last occasion of yellow-brown liquid, which was slightly stercoraceous; this was the first time any suspicion of a stercoraceous character appeared in the vomit. As she was not getting better her husband wished to have her at home, and she was discharged on October 19. For about a month she remained much the same, but towards the end of November became much worse, and I was sent for on November 26. I found her in bed in great pain, the abdomen was very greatly distended, evidently with flatus, and as the paroxysms of pain occurred the coils of intestine were plainly visible standing out now here and now there, like the prominent portions of a moving child in the thin-walled abdomen of a pregnant woman. The pulse was feeble and quick; the temperature 99° . There was great emaciation, as the patient had kept hardly anything in the stomach for ten days, during which, too, there had been no stool. The last day or two the vomit had become faecal, and I was shown half a chamberful of pure liquid faeces which had been ejected that afternoon and evening. The pains and vomiting came on in paroxysms day and night, frequently recurring; they were, however, worse in the afternoon about 4 p.m., and they seemed to come up the right side of the abdomen, cross over in the direction of the transverse colon to a point in the left hypochondrium, where there seemed to the patient to be a spot where there was an obstruction which nothing could pass. Had I never seen the patient before I should have thought her to be suffering from acute intestinal obstruction requiring immediate operative measures. Knowing her previous history I did not think so, notwithstanding the large amount of faecal vomit. The flatulent distension of the intestines, the four o'clock aggravation of symptoms, and the direction of the pains from right to left, all plainly indicated lycopodium as the suitable medicine. I reflected that she could hardly have been in the hospital so many weeks without lycopodium having had a fair trial and apparently without success, but it was possible that she had had it in only comparatively low dilution, so I decided to give it high, and leaving her at the time the highest I had with me, viz., the 30th, in a little water, I sent her on reaching home two powders of the 1,000th, one to be taken at bed-time and the

other the following morning, and gave strict orders that neither food nor any other medicine should be taken till I had seen her again. The next day she was better, the pain and vomiting had ceased, and a little flatus had passed *per rectum*. She was then told that no more medicine would be given her at present, but that the powders would be allowed to work in the system, and that they would be sure to do her a great deal of good. The fasting was kept up for forty-eight hours, and she was then put on a strict non-meat diet. The result was satisfactory. In a week she was up and about, and putting on flesh. A week later still better. In the following week the abdomen was more distended again, but there was no pain or vomiting; it threatened to come on one day, but she went to bed and starved for thirty-six hours and it was averted. She continued to gain strength, and the following week came to see me and said she had not felt so well for months. She went on improving and gaining strength and flesh through December and January, but towards the end of January the abdomen began to swell up again with flatus, the bowels became constipated, and she had a little pain. On the 24th she began to menstruate for the first time since the operation in the hospital, a period of eight months. Pain came on and lasted without ceasing for three days. After a slight intermission it recommenced with vomiting, but not fæcal. She was put on lycopodium again, but without result. As well as her abdominal symptoms, there was a thick jelly-like discharge from the nose, which felt constricted and aching at the root, and there was also a frequent loose-sounding cough without expectoration, and without physical signs in the chest, which I considered to be of reflex origin and caused by the abdominal irritation. These two additional symptoms seemed also to be covered by lycopodium, and it was given in all dilutions in turn, from the mother tincture to the 1,000th dilution, without the slightest effect. At 4 p.m. on the 15th the vomit again became fæcal. Silica 30, η v., every three hours was given. On the next day there was some improvement, and the day after diarrhoea set in, there being as many as nine evacuations between 3 and 9 p.m., but no wind passed. The next day a fully formed stool was passed, to be followed in the afternoon by more diarrhoea with much pain in the bowels and general coldness and shivering, much flatulent colic, but no passage of wind. The next day a well-formed stool was passed, followed by free passage of wind, with much general relief and improvement.

The improvement, however, only lasted a week, when the pain

and accumulation of wind returned, but this time there was no constipation, the bowels being opened freely every day, but there was, nevertheless, no passage of wind.

Lycopodium, though apparently so well indicated, had lost its charm, and so a search was made in the *Materia Medica*. The choice, after a long search, seemed to be narrowed down to three drugs, lycopodium, thuja, and raphanus. The patient had the following symptoms found under lycopodium: Contractive, cramp-like pain in the abdomen, which is distended; incarcerated flatus; the flatulence cannot pass and causes much pain; noisy flatulence in the abdomen; constant fermentation in the abdomen which produces a loud croaking sound. Symptoms worse at four p.m. Pains go from right to left. Dry cough day and night.

She had the following symptoms found under thuja: Inflation of abdomen with contractive and spasmodic pain; grumbling and borborygmus in abdomen, as if the abdominal muscles were pushed outward by the arm of a foetus (the *Materia Medica* adds but painless, but with the patient it is very painful, and so in this particular there was no correspondence); shortness of breath from fulness in the upper abdomen; accumulation of mucus in posterior nares. This gave a fairly accurate picture of the patient, but was not so close as lycopodium. The raphanus symptoms exhibited by the patient were: Vomiting of faecal matter; cough starting from the epigastrium; pains from incarcerated flatus, coming on in paroxysms; colon and other intestines project in tympanitic tumours all over the abdomen, which is flaccid in the interval. No emission of wind takes place for a long time either up or down. Bowels move, but no flatus passes. Wind accumulates and greatly distends the abdomen and hinders breathing. Accumulation of mucus in the posterior nares.

Here at last, surely, was found the similitum. Raphanus, or the wild radish, had all the charm of novelty to me. I had never used it before, nor even read any account of it, and now staring me in the face in Clarke's dictionary were all these symptoms so exactly corresponding to those of my patient. Vomiting of faecal matter is a prominent symptom under raphanus, and does not occur with lycopodium. On referring to "Kent's Repertory," I find several medicines under faecal vomiting. They are: Ars., bell., bry., colch., cupr., nux-v., opium, plumb., raphanus, sulph., and thuja, opium appearing in heavy type. But the symptom of raphanus, which seemed to me the most peculiar and characteristic, is the one: "Bowels move, but no flatus passes." It was of frequent occurrence with the patient

that the bowels would act quite normally for days together without any passage of wind whatever, and without any relief to the flatulent colic. This seemed a strange symptom, and I was therefore very glad to find it was produced by raphanus. Feeling therefore confident that I had found the similimum to her complaint, I told her I thought I was going to cure her at last, and gave raphanus 30, m v. , to be taken every four hours. This was on March 11. On the 12th wind began to pass freely with diarrhoea, the abdominal distension went down, and all pain ceased. The diarrhoea continued, several stools a day, which were pappy or like thick soup, for five days, and in the meantime wind passed freely and she was much better. The raphanus was then stopped for three days and was then to be resumed. Unfortunately, my gratification as to the result of the medicine was destined to be of short duration. A few days later, notwithstanding that the bowels acted regularly, evacuating a well-formed, solid stool every morning, the flatulence began to collect again, and ceased to pass *per anum*. The old symptoms returned, and I find that I noted on March 24 that she had brought up half a chamberful of faecal vomit, and with remissions of short duration this state of things went on to the beginning of the next month. Meanwhile, she was getting much reduced in strength, and lost 9 lbs. in weight in the course of six weeks. She had been very careful in her diet, but on April 7, as she expressed it, she felt desperate, and took a glass of stout and some bread and cheese, an hour after which the wind passed in large quantities with great relief. She repeated the stout in the evening with the same result, and continued to take two glasses of stout daily with great comfort to herself, one glass with fish or cheese for dinner and one without food at 9 o'clock in the evening. She remained much better for a month, passing wind freely all the time, and the bowels being well opened. She, however, had an increase in the cough, which was more or less constant night and day, and also an increase in the watery discharge from the nose, which was worse in the morning, and did not stiffen the handkerchief. The irritation to cough was at the pit of the throat, and the cough shook the whole body and caused a bursting pain in the head. The continuance of these symptoms led me to think that though the flatulence was better the underlying cause had not been removed, and that symptoms would return. They did. Another attack came on which lasted from May 3 to 9, and again a still worse attack with much faecal vomiting commenced on the 15th.

On the 19th her husband came to me quite in despair, his wife was worse than ever, and he himself could get no rest and was getting worn out. Did I think I could do anything for her and was it any use her taking medicine any longer? It was discouraging, the most carefully selected remedies after a promise of success had failed. The exploratory operation at the hospital had disclosed an amount of adhesion and matting together of the intestines, which one might reasonably think formed a mechanical obstacle to any real improvement. One of the three likely medicines, viz., thuja, had not been tried, and so I prescribed thuja 12, m v., every four hours. "Would it do any good?" asked the husband. I replied that it was a medicine that had not been tried before and it might, but I could promise nothing, and remarked that with regard to the case I had pretty nearly come to the end of my tether. With that he went away.

For what occurred subsequently I am indebted to an interview with the husband several weeks later. I may say in passing that he was most devoted to his wife and is a respectable man employed by one of the railway companies, thoughtful, and fond of reading, altogether a very favourable specimen of the British artisan class. In well-chosen and graphic words he gave me the following narration which I have written from notes taken at the time:—

"I went away from your consulting room, Sir, very downhearted from your last remark; I kept saying to myself, 'Doctor's come to the end of his tether. I've come to the end of my tether; it seems we have all come to the end of our tether.' When I got home my wife said directly she saw me: 'You need not tell me; I know the doctor thinks he can do no more for me.' I replied, trying to cheer her up, 'Oh, no, he has sent you some fresh medicine'; and I gave her a dose at once, but it was the last. She said she had been thinking the matter over and she had decided not to take any more medicine, but to leave it to God Who, if He wished her to get better, could make her well without medicine. It had happened that a day or two before a lady had called to see my wife who belongs to Mrs. Eddy's Church, and she had talked to her for some time and said she was going to send her a book which she would like me to read. The book came the next day and I read it and was

interested, so that I went to one of the week-day services in Mrs. Eddy's Church. Several people there gave their experiences of people being healed by Christian science teaching and one case was very like my wife's. It happened that the lady called again, and hearing that I had been impressed by what I had seen and heard, offered, if I were willing, to send a Christian science practitioner to see my wife. I said I should like her to do so. He came on the following Saturday and stayed about an hour. He did not do anything; he only talked to my wife and explained to her the principles of the science and how she would get well. After he went she had four hours' sound sleep and without the loud noises in the stomach which she had always had in her sleep for months. When she woke she was without pain and felt better. She slept the whole of the next night, and had no pain next day. In the following night she woke up at two o'clock in the morning and said to me, 'I am sure I shall get better; there is something inside me tells me I am healed.' She got up the next day, which was Monday, and sat by the window, and on Tuesday morning she woke up with a healthy appetite and afterwards cooked and ate a good dinner, and on Wednesday she went out and did some marketing.

"The practitioner called the following Saturday, and said he was not at all surprised to find her down and opening the door to him. He was sure it would be so and she would go on getting stronger and stronger till she was quite well. And so it has been. She can now take long walks without feeling tired. She has no pain and the bowels act regularly, the wind passes freely, but she does not seem to make so much; she has a good appetite and eats anything she fancies, and it never disagrees with her, and she sleeps soundly. Her cough is quite gone, and there is no discharge from the nose. She is putting on flesh rapidly."

This was the husband's story. I can confirm the truth of it as far as the improvement in the patient is concerned. At my request she came to see me. She did not look like the same woman, and had evidently put on a stone or more

in weight. The abdomen on examination was found to be quite soft and not distended, though full; there was no rumbling or gurgling, and no tenderness or hardness of any part. A movable left kidney was found (as it was in the hospital), but it was causing no symptoms. The catamenia had become regular exactly to the date, lasted four days, were rather scanty and without pain. She weighed 9 stone, and said she was stronger than she had been for fifteen years.

I saw her again at the end of last August; she had been away for a holiday, and had walked miles over hill and dale, and felt stronger and better than ever, without the suspicion of a return of any of her symptoms.

She came to see me again at the end of November. She continued quite well and was getting stout. Menstruation still quite regular; she expressed herself as feeling better than she had ever done in her life.

I hope I have not wearied you, gentlemen, by my long description of this case. The method by which she was finally cured is one, however little we may like it, we cannot afford to ignore. The sect of Christian scientists and mental healers would not have made such headway as they have recently done in America and this country unless they had something to show for it. No doubt they have many failures; in this they resemble other systems of cure; but they also have some genuine successes, and a few of these go a long way. These people are forcing the public and the medical profession to pay more attention than they have hitherto done to the immense influence that the mind has on the body, and to the fact that different mental attitudes are correlated with corresponding physical states.

Hahnemann effected a revolution in the treatment of the insane by showing how the reverse of this holds good, how disorders of the bodily organs are often the cause of diseases of the mind, and that to cure the patient's mental disease we should select a remedy which is a simile to his body condition. And we all know how he was the first to insist on the value of the mental symptoms in the pathogenesis of drugs, and in their selection for prescribing—a

discovery so far in advance of his age that now, a hundred years later, his followers are the only ones who put it into practice. So we as homœopaths should, I think, take a special interest in these cases of mental healing and should not be deterred by the associations of quackery with which they are surrounded from enquiring into any cases that may come in our way. As scientific men we cannot believe that these cures are the result of chance; they must depend upon law like all other phenomena, and it is for us to find out, if we can, the conditions and mode of working of that law in order that we may add another implement to our therapeutic armamentarium.

In support of what I have just read I will quote some remarks from a thesis written by Dr. Goddard, and published in the *American Journal of Psychology* for 1899 (vol. x.). This quotation is taken from a footnote to Professor William James Gifford Lectures, entitled "The Varieties of Religious Experience." Lectures iv. and v. of this book deal with the subject of Christian science in a very interesting and suggestive way.

Dr. Goddard writes: "In spite of the severe criticism we have made of reports of cure, there still remains a vast amount of material, showing a powerful influence of the mind in disease. Many cases are of diseases that have been diagnosed and treated by the best physicians of the country, or which prominent hospitals have tried their hand at curing, but without success. People of culture and education have been treated by this method with satisfactory results. Diseases of long standing have been ameliorated and even cured. We have traced the mental element through primitive medicine, and folk medicine of to-day, patent medicine, and witchcraft. We are convinced that it is impossible to account for the existence of these practices, if they did not cure disease, and that if they cured disease, it must have been the mental element that was effective. The same argument applies to those modern schools of mental therapeutics—Divine Healing and Christian Science. It is hardly conceivable that the large body of intelligent people who comprise the body known distinctively as Mental

Scientists should continue to exist if the whole thing were a delusion. It is not a thing of a day; it is not confined to a few; it is not local. It is true that many failures are recorded, but that only adds to the argument. There must be many and striking successes to counterbalance the failures, otherwise the failures would have ended the delusion.

“Christian Science, Divine Healing, or Mental Science, do not, and never can in the very nature of things, cure all diseases; nevertheless, the practical applications of the general principles of the broadest mental science will tend to prevent disease. We do find sufficient evidence to convince us that the proper reform in mental attitude would relieve many a sufferer of ills that the ordinary physician cannot touch; would even delay the approach of death to many a victim beyond the power of absolute cure, and the faithful adherence to a truer philosophy of life will keep many a man well, and give the doctor time to devote to alleviating ills that are unpreventable.”

We may remark with regard to the patient, Mrs. R., that the seat of her illness, the alimentary tract, is one that is throughout largely under mental influence and is intimately connected with the emotions. It is doubtful whether any considerable emotion passes over us without telling upon the processes of digestion, either to quicken or depress them. Business worries and anxiety are the cause of numberless cases of dyspepsia. Fear parches the mouth by the suppression of the flow of saliva. Grief will cause a spasmodic choking sensation from contraction of the muscles of the pharynx. Vomiting is excited by the sight of objects of disgust, or by the mere suggestion than an emetic has been taken. Apprehension often brings on an attack of diarrhoea. And with regard to flatulent movements in the bowels, it must be within the observation of all of us that they are largely influenced by emotion. One patient of mine was not much troubled with it except when she went to church or a concert, or to pay visits, when the most distressing noises would come; another, an hysterical girl, would, when alone and believing herself to be unobserved, remain quiet, but would immediately have loud borborygmus and belchings

when the doctor or any friend came to see her. Dr. Arthur Leard writes: "During the Crimean War, when I was physician to the Smyrna hospital, I witnessed several cases in which distension of the digestive cavity was induced apparently by the marvellous ingenuity of soldiers in feigning diseases. Several of our patients became affected with phantom tumours of the abdomen. They always disappeared under chloroform."

The patient, Mrs. R., was also of the mental temperament that is open to suggestion. When I gave her the one dose of lycopodium 1 m, I did so with a good deal of confidence, thinking I was giving the similimum, and perhaps with a certain amount of parade. The single dose, which was not to be repeated, evidently impressed her and she was quite well for two months afterwards. Unfortunately, after three or four weeks I lessened the impression by giving her other doses of a lower attenuation. I should have told her instead that she would never require another dose of medicine in her life, and then perhaps, instead of having a case of mental healing to bring before the Society I should have been able to add my testimony to the virtue of the single dose and of lycopodium 1 m.

Similarly, though in a less degree, raphanus and the porter had an effect lasting for a time. But these impulses were not strong enough to have a permanent effect. These patients are like the rocking stones met with in some districts. An ordinary push will move them, but the centre of gravity is not displaced, and they swing back to their usual position. A push violent enough to alter the centre of gravity is required to dislodge them and place them in a new position. This violent push our patient received from the Christian science people, and her mental centre of gravity has from that time been changed, and has brought with the change an altered bodily condition.

The question remains, Can we physicians imitate so much of the methods of the Christian scientists as will produce the same results? Possibly, but there are difficulties. In the first place, we could not so well as they afford to have failures. It would not do

for a medical man to assure a patient with much show of positiveness that he would speedily recover perfect health, and for an autopsy to reveal an abscess in the brain. People might think his own brain was not quite healthy, and his practice might suffer. We should have to be very sure of our cases. This is not easy. In the case of Mrs. R., I do not think any of us would have supposed that she would be cured by a mental impression. Had not the abdomen been opened, tuberculous masses found in the peritoneum, and the intestines all matted together and bound down with adhesions, a physical condition quite sufficient to account for flatulent collections and obstructions, and perfectly irremovable by any idea that might find lodging in the patient's mind?

But supposing this difficulty surmounted, and that we are certain that the case is one suitable for mental treatment, the further question arises, Have we the means at command for making a sufficiently forcible impression? Here, again, we are at a disadvantage. However earnestly a doctor may explain to a patient that all his symptoms are dependent on the state of his mind and that he need not have them at all if he would only consider things in a proper light, he is not likely to gain much credence. The patient will think that the doctor believes he is shamming, and will be more likely to feel affronted than convinced.

But when the same thing is told them by a Christian scientist, who backs it up by unfolding a sort of religious philosophy which comes to them with all the force of novelty, they give him their attention and perhaps their faith. And with regard to their doctrines, they are not all such utter bosh as some of Mrs. Eddy's writings would lead one to expect. They have some able writers amongst them, such as Mr. Horatio Dresser, Mr. Wood, and Mr. Trine. No one who has read Trine's "In Tune with the Infinite" can fail to be struck with the persuasiveness and even the truth of much that he says. So it is not surprising, when persons are brought to a state of desperation by long-continued illness from which they have obtained no relief though they have consulted many physicians, that they should be ready

to pay attention to some one who can with an air of authority and conviction unfold what is to them an entirely new view of disease and health, supported, as it is, by an appeal to what lies deepest in their being, viz., their religious sentiments. Their want of success from other efforts makes them the more susceptible to the new influence, and they are able to surrender themselves to the faith which cures.

It is not easy to see how we can approach a patient with the same confidence and authority, especially if we have previously tried our best on ordinary medical lines and have failed. Our previous failure is against us, and the patient not only needs a change in treatment, but also a change in the personality that is to administer it.

Then, again, our scientific training tends to make most of us unsuitable agents for the administration of mental therapeutics of this kind. The essence of scientific method is the gathering of knowledge from all quarters, its careful comparison, and slow processes of reasoning, its cautious drawing of conclusions, and its watchful and sceptical attitude in the face of experiment.

Every treatment of a patient is an experiment, and to make sure we are drawing the right conclusions from the experiment, we have to be very cautious that no additional causes are at work other than those we know we are experimenting with. Especially do we wish that the patient's statements as to results may be unbiassed and true. This attitude is inconsistent with trying to warp the patient's mind in one direction or the other. It is by the neglect of this scientific attitude that so many unreliable provings of drugs have been made, and so many mistaken cases of cure have been recorded; and the progress of therapeutics has its path arrested by an accumulation of rubbish resulting from carelessness or preconceived opinions. The man of scientific mind feels this acutely, and it goes against the grain for him to exchange his habitual attitude of doubt and expectancy for one that involves positive assertion based on no sufficient proof. He must be a good actor to be able to do it, and we are not all good actors. Nevertheless, as observers of life we are bound to confess that a man with

unscientific methods and habits of thought, but with plenty of self-confidence and power of impressing his patients, will often succeed where the other will not, showing how large a share mental influence has in therapeutics. His success, however, is for himself and his patients; he will not add anything to medical knowledge. He is more likely to cause confusion by publishing as cures by drugs cases which owed their recovery to suggestion.

There is one method we may adopt which is free from these objections, though it may have others of its own. I refer to treatment by suggestion of patients in the hypnotic sleep. This is a powerful and often successful method of acting on the patient's bodily condition through what has been called his subliminal consciousness or his subconscious mind. It has been used much more on the Continent, and especially in France, than in this country, but should, I think, receive much more attention from our nervous and mental specialists than it has so far done. A science of the subject is being gradually built up, founded on the careful experiments of able investigators, which is likely to take a prominent place in the medicine of the future, in the special department of psycho-therapeutics.

But I have taken up sufficient of your time, and must leave it to the meeting to discuss how far we as physicians can employ methods of mental suggestion in our treatment.

Dr. HAWKES (in the chair) congratulated Dr. Stonham and thanked him on behalf of the members for his excellent paper. He said the author had one great advantage in treating the case he had detailed which practitioners did not always possess, namely, he knew exactly what the inside of a patient looked like. He (Dr. Hawkes) was particularly anxious to hear what Dr. Clarke might have to say as to the probable duration of the action of lycopodium 1 m. There was no doubt the Christian scientist people had some advantage in dealing with Dr. Stonham's case after it had been treated so carefully by others.

Dr. BLACKLEY thought the case was one of extreme interest and hoped that the last had not been seen of it. He threw out the suggestion to Dr. Stonham that the patient should be asked to attend the hospital for a consultation at some definite period,

say twelve months or two years, from the date when the first consultation was held, that she should be put under an anæsthetic and examined by experts. They would be then in a position to say definitely whether she was cured or not. He had had the opportunity of seeing the patient twice since she left the hospital, and when he saw her in May last he was of the opinion that she was already very much better. When he saw her for the second time last October, she was to all appearances perfectly well. He had nothing to say with regard to the "mental science" treatment, except that it was "passing strange."

Mr. KNOX SHAW said the case was of very great interest from many points of view, and was one of a class of cases of which he had seen a few. In the first case of the kind he saw, and on which he operated, the patient was a small boy, suffering from acute intestinal obstruction, with fæcal vomiting, and apparently *in extremis*. An exploratory incision was made, and a condition of fibrinous tubercular peritonitis was found with adhesions which could not be separated. He gave an unfavourable prognosis, but the patient was still living and flourishing. The patient was treated mainly with silica in high dilutions. He was asked to see a similar case about a year ago. The patient was a young girl, who was seized with acute intestinal obstruction and fæcal vomiting, and her condition was such that he feared she would hardly stand an operation. On operation it was found that the patient had most marked tuberculous peritonitis, with matting together of the intestines. She recovered from the intestinal obstruction, but, unfortunately, died two months later from another trouble. The *post-mortem* examination revealed the fact that the tuberculous material, which was most palpable to the naked eye on the occasion of the operation, was almost entirely gone. Therefore, when he operated on the case Dr. Stonham had brought forward, he believed the patient would ultimately get well.

Dr. CLARKE said the only question in his mind in connection with the case was whether the cure was not the effect of a single dose of thuja that was given. The President had asked how long the effect of a dose of lycopodium 1 m. would act. He could not say without the book, but thuja was a very long acting drug, and six months was very often not enough to exhaust the action of a dose of it. It was rather fortunate for the patient that the husband managed to administer that single dose, and it was also fortunate that he did not administer another dose, because the subsequent dose would very probably have antidoted the first.

He thought, therefore, the credit of the case lay between the single dose of *thuja* and the Christian scientist.

Dr. DYCE BROWN thought from the history of the case given by Dr. Stonham, that the patient was of the neurotic type. It was very easy to be wise after the event, but, if he had had charge of the case, the medicines he should have been inclined to give were *lycopodium*, which was well indicated, *ambra grisea*, which was distinctly indicated in cases of the neurotic type, ginger perhaps, and *valerian*. He thought those medicines would have met the case more thoroughly than the otherwise excellent treatment adopted by Dr. Stonham. Any one who had read Mrs. Eddy's book on the subject of Christian science must have been struck with its utter abysmal logic; it was neither Christian nor scientific. All the cases of cures of which he had heard connected with Christian science had been cases of neurosis of one form or another, and the so-called treatment of the healer was really nothing more than mesmerism or hypnotism. The Christian science healer had the effect of being a hypnotist for the time being. He had not the smallest doubt, as Mr. Knox Shaw had said, that the *personnel* of the physician was of the utmost importance. The physician might be a very good man indeed, but might not have that particular power over the patient necessary to bring about a cure.

Dr. ROBERSON DAY testified to the alarming nature of the symptoms of the patient whose case was under discussion. When he first saw her she was writhing in agony, and the abdomen very markedly showed the convolutions of the intestines. After removal to the hospital, the patient's abdomen was opened, and he ascertained from those present at the operation that the matting was due to tuberculous deposit. The outlook for the patient was of a most gloomy character, and he remembered writing to a gentleman very much interested in the case, telling him that there was very little prospect of recovery. He concluded from the operation that there were adhesive bands of some kind producing the contortions and visible convolutions. He was very pleased to hear of such a satisfactory termination to the case, but was in doubt on some of the points as to the entire clearance up of the deposits. He had seen some cases operated on where there was matting of the intestines which had not made the satisfactory recoveries referred to by Mr. Shaw. There was very little doubt that the mental effect was largely responsible for the cure. The paper was exceedingly interesting, because it impressed upon practitioners the need of convincing a patient of their ability to

cure. He remembered treating a patient who said he could not swallow ; he was a pitiable object, very much wasted, who would never move without a spittoon, into which he was always spitting his saliva, because he could not swallow. The patient could scarcely get any nourishment down at all. He diagnosed hysterical stricture of the œsophagus. He told the patient that he intended passing a tube and giving him some good food. He accordingly passed an œsophageal tube, and to the surprise of the patient gave him a jug of milk, thus convincing him there was no stricture. Afterwards he watched the man eat a bowl of bread and milk. From that time the patient took his meals naturally.

Dr. GOLDSBROUGH thought that every medical practitioner should be a psychologist and a healer from the psychological point of view, as well as a healer by medicines. He saw no reason why homœopaths should not be able to formulate their principles of mental influence as well as their principles of administration of medicines. He did not think the statement that the case was a neurotic one, or that it was treated by suggestion, was sufficient to account for the influence. There was something else. First of all, there was the actual physiological effect of brain states upon the body. Dr. Stonham had called them corresponding physical states. He would like Dr. Stonham to say precisely what were corresponding psychical and physical states, as to what localisation in the brain corresponded to the heart or intestines, or any other part of the body. Although there was every reason to think that all of the viscera and all the vital organs were represented in the brain, the principle was not yet worked out. It seemed to him that the Christian scientist had an advantage in two points with regard to the influence which a man could exert over a patient. He joined issue with Dr. Dyce Brown in saying that Mrs. Eddy's book consisted of abysmal logic. There was one central point in the book for everyone who wished to do anything in the way of influencing a mental patient, namely, the inspiration of a faith in a monistic interpretation of the universe as distinct from an atomistic. The tendency of science was towards an atomistic interpretation, *i.e.*, the splitting up of everything into fragments, but the effect of the Christian scientist's idea was to inspire confidence in the monistic interpretation. Running through the book there was the notion of one God, and that was really the central idea, and the successful idea, because if a patient could be inspired with confidence in union or oneness between the doctor and himself, as universally or infinitely true, a note was struck in his experience which was practically

certain to have a great influence on his subsequent mental tone and anticipation. That was really the root principle of Christian science. It was not Christian except in so far as it was inspired by Christian benevolence. Whenever the Christian scientist came on to the field he inspired a confidence by his Christian benevolence, placing himself on a level with the patient, allowing the patient to identify himself with the stronger mind, which at once gave the necessary confidence. It was a stretch of the imagination to say on that basis that the patient was sure to recover; that was beyond actual knowledge, but it worked in a great many instances, as it did in the case under discussion. But there was a great deal more in this than suggestion. The principle of suggestion was similar, but even for suggestion to work there must be some positive truth to lay before the person under treatment. In the emphasis of this positive truth lay the difference between Christian science and mere suggestion. When any one was mesmerised, they could be influenced to a very large extent by suggestion, but, in that case, intelligence was merged in loss of memory, which was a different thing from curing by a positive principle when the latter was brought into play. Another principle involved in Christian science was that directly confidence was inspired, a negative absence of anxiety took hold of the patient, causing a rest of the whole functions, whereby the patient might fall asleep more readily; at any rate, he became contented for the time being, and contentment strongly predisposed to recovery from illness. The two principles of positive unity and a negative absence of anxiety appeared to him to lie at the root of the Christian scientists' principles. There was no reason why doctors should not adopt those principles if they believed in them. Of course, if they took up the atomistic view they could not, but if they believed in the monistic they could. There was nothing to prevent the homœopath, who, above all persons, believed in a single principle for the use of drugs, believing also in a single principle for the influence of the mind.

What was the state of the patient at the present time? Dr. Goldsbrough thought in all probability she had latent tuberculosis, that she would come under Dr. Stonham's treatment later on, and that he would have to apply again the great principles mentioned for her health. Dr. Goldsbrough did not say they would work; but it was absolutely essential to every medical man that he should never display loss of confidence in his own power. Even supposing he had come to the end of his tether, he should never say so;

it served to weaken the confidence of the patient in any possibility of recovery. Dr. Goldsbrough strongly protested against Dr. Blackley's proposal that the patient should be brought under the influence of suggestion in an opposite way. He thought it would do her a great deal of harm to put her under an anæsthetic and try to find out whether she was well or not, because it would suggest to her that she had something the matter with her. He enquired why Dr. Stonham did not give the patient *pulsatilla* during delay in menstruation, especially as she had not menstruated for so long. It seemed to him that *pulsatilla* might then have been used with advantage.

Dr. MADDEN said it had occurred to him more than once while Dr. Stonham was reading the paper to ask why he did not think of giving either *ignatia* or *tuberculinum*, both in high dilutions. He quite confirmed Mr. Shaw's belief that in all probability the operation entirely relieved the mechanical difficulties of the tubercular peritonitis. Mr. Lawson Tait used to tell his students in Birmingham more than twenty years ago that the most hopeful course to adopt in tubercular peritonitis was to open up the peritoneum, whether anything else was done or not. There was no doubt that in the case under discussion a very large neurotic element was present, as there was in nearly all chronic cases. The neurotic element frequently overshadowed the somatic entirely, and the difficulty was to know how to deal with such cases. If the practitioner possessed the entire confidence of the patient, and was confident in himself, he could generally succeed without further help; but if not, he ought to be willing to call in the help of those who were able to induce the necessary influence on the mind to cure the patient. He would certainly not call in as consultants and coadjutors the people who called themselves Christian scientists, because they were absolutely ignorant of and opposed to the use of medical means to cure patients, whether there were a definite disease visible or not. Such people were not worthy coadjutors; but there were medical men who had made a special study of the principles and practice of hypnotic suggestion, and other means of producing the same effect, in a truly scientific and thoroughly successful way. Such men should not be looked upon as rivals; most of them, if not all, were trained medical men, and, working scientifically with the practitioner, cured the patient of that part of the complaint which was beyond their personal help. He thought the lesson to be learned from the paper was that, where a neurotic element overshadowed the bodily element, special help could reasonably be called in, not from outside, but inside the profession.

Dr. STONHAM, in reply, said that Dr. Blackley had suggested that the patient should attend the hospital in a year or two's time and that she should be chloroformed in order that her condition might be diagnosed. He should be very unwilling indeed to lend his assistance to such a proceeding unless the patient had a return of the symptoms, because he thought it would be the surest possible way of bringing back her complaint. The patient was a woman who was very open to suggestion, and it would really be cruel to her to adopt that course. As she was at present well, he was certainly inclined to let her remain well. Mr. Shaw thought the case was a surgical triumph. He agreed with Mr. Shaw that very often, opening the abdomen in a case of tubercular peritonitis was a very great benefit, but in the present case the symptoms were very much worse after the operation than they were before. The patient never had fecal vomiting until a month or six weeks after the operation, all the more severe symptoms occurred afterwards; so that if it was a surgical triumph it was a triumph through a course of very considerable aggravation lasting over a very long time. Dr. Clarke thought the cure might be due to the action of the thuja. He would certainly have liked a longer time to elapse between giving the thuja and the patient's coming under the Christian scientist's influence. It complicated one's idea as to what was the real cause of the cure. But thuja was not better indicated than raphanus or lycopodium. Dr. Dyce Brown said he would have given ambra grisea, ginger or valerian. They were not so well indicated by the symptoms as the drugs he gave, and of course, one could not give all the drugs in the Pharmacopœia, but had to choose the one that was most indicated. He agreed very largely with Dr. Goldsbrough's interesting remarks. He did not give pulsatilla during the absence of menstruation, because other drugs seemed to be better indicated. Before the operation was performed the absence of menstruation was taken into consideration, sulphur and lachesis being given, with the result that they brought on the menstruation once or twice. When lycopodium was given, the menstruation reappeared after an absence of eight months, so that he was not excessively anxious about the menstruation, and did not therefore give pulsatilla. He was under the impression that the patient was given tuberculinum during the long years he had treated her before the operation. He agreed with Dr. Madden's remarks with regard to hypnosis, believing it was through suggestion in the hypnotic sleep that physicians could best treat such patients. He saw nothing derogatory in a man who took up psycho-therapeutics as a

specialist being employed as hypnotist, indeed, he thought it was a most scientific proceeding, and he believed they would gain the greatest power in that way over the class of patients referred to in this paper. The practice would open up new laws of mind, and medical men would gain a much better understanding of the relation between the mind and the body through hypnosis than in any other way.

THE HOMŒOPATHIC TREATMENT OF "BILIOUS ATTACKS."¹

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IT is not my intention to deal with this subject in an exhaustive manner, nor to discuss the etiology or pathology of the condition or conditions which come within the scope of the term "bilious attack."

In one or two works to which I have referred I see the term is practically a synonym for migraine. Such is not my idea, though some of my cases no doubt would come under the term migraine. It is impossible to make hard-and-fast rules in the classification of disease, and the more we can rid ourselves of pathological theories in homœopathic work the better. The term "bilious attack" in the meaning of this paper applies to periodical attacks of headache and vomiting, or vomiting and headache, the vomit being usually of a bilious character. Whether the theory that these cases are of hepatic origin, or a sort of nerve-storm, or due to uric acid, be accepted matters little for therapeutic purposes, since it is only the symptoms and a close individualisation of each case that can lead to the selection of the best remedy.

In the treatment of these cases as well as many, if not all, others, we may attack the disease in two ways, which I would call the direct or the indirect; in other words, we may

¹ Presented to the Section of Materia Medica and Therapeutics, January 4 1904.

select a drug which produces a picture of the attack, or a drug which meets the underlying predisposing cause. In all probability it is only this latter method which will really cure the disorder, and should therefore be chosen by preference if possible. I will deal first with the remedies that meet the actual attack, and most of these, in my experience, are drugs that act principally on the liver—iris, carduus marianus, chionanthus, sanguinaria, &c.; of these I have had most success with iris, but do not therefore suggest that iris should be the first remedy tried, the symptoms of the case must decide.

I fear most of my cases are fragmentary, but all will illustrate some point. Here is an iris case.

Case 1.—M. C., aged 55, came to the out-patient department, May 1, 1901 (first notes by Dr. Ross). Duration of illness twenty-eight years. Complains of sick headaches, about two a month, more frequent of late. Feels queer the day before, face goes yellow; then headache comes on, pain general, cannot open eyes, vertigo. Food seems to stop half-way down with a feeling of suffocation. Vomiting lasts one day, very acid. Amenorrhœa twenty-eight years; since birth of last child. Previously attacks less severe; constipation very obstinate. For six months has always had pains after food. Ars. 3 was ordered.

May 15.—She reported decidedly less dyspepsia. Had a bad attack last week. I elicited the following additional symptoms. The headache is generally more on one side and alternate sides. There is a great deal of shivering during the attacks; rigors (?) Feels very cold during the attacks. Jaundice during and after the attacks, and the urine is very dark coloured.

On examination the liver and gall-bladder were not palpable, though abdomen was very lax. There was marked epigastric pulsation. She loses flesh after each attack; used to be very stout. Iris 2x, m v., t.d.

June 5.—Feels much better. Has had no attack. Rep.

July 3.—Is much better. Has had only one attack, much slighter than usual. Rep.

August 14.—A slight attack and of different character; less sickness, only about one hour instead of all day; great trembling all over, shaking the bed; with cold feet; no pain. Gets a sort of agitated trembling nearly every day. Great pain in the chest after meals from front to back, to between the shoulders; dreads

eating. Bowels better since taking iris. Is very low-spirited and irritable; must be left alone. Ign. 6 t.d.s.

August 28.—No more attacks. Tightness across the stomach after meals, increasing after supper, 8 to 9 p.m. Rep. 2x. She has not reported herself again. It will be observed that as result of the iris she went from May 15 till end of August with only two slight attacks, instead of severe attacks once a fortnight or oftener.

The characteristic indications of iris versicolor are nausea and vomiting of sour or very acid matter, sometimes ropy mucus hanging in strings from the mouth (it also has saliva of similar character), great burning distress at the epigastrium. The headache is usually one-sided, but may be across the forehead. Blurring of vision sometimes precedes the attacks. Eating sweet things may excite the attacks. In iris the gastric symptoms predominate as a rule. The remedy which perhaps most closely resembles iris is kali bichromicum, but it has some very definite characteristics, and in kali bichromicum the head symptoms predominate. Its keynote is blurring of vision before the attack, which passes off as the headache comes on, and the headache usually settles over one eye. This symptom has, I think, never failed me. Another peculiarity is that the attack frequently begins in the morning and increases and decreases with the sun.

Here is a typical case.

Case 2.—E. A., aged 24, boxmaker. Ill three years; seen March 1, 1902. Headaches at least once a week, beginning in frontal region, jumping pain. Begins as a mist before the eyes, which goes off when the headache begins, and then bad retching supervenes. Has to give up work, and is very bad the following day. Face flushed during headache, which affects the frontal region on both sides. Kali bich. 30 o.n.

March 15.—Sickness gone; headache no better, but does not feel so bad with it. Rep. 200 o.n.

May 10.—Has continued the medicine till last week, and was better while taking it. The attacks have not been nearly so frequent, only three since commencing the treatment. Any extra worry or excitement makes her worse. Is constipated, bowels act only once or twice a week, stools large. Bry. 30, n. and m.

May 31.—One headache in three weeks. Bowels better. Rep. kali bich. 200, o. 4 ds.

Case 3.—Mr. H. consulted me June 9, 1903, for bilious attacks, from which he had suffered all his life more or less, not so severe lately till the last month. Attacks begin with specks before the eyes and dim vision, then headache accompanied by clearing of the vision and the sickness. The pain is one-sided and very sharp. Kali bich. 30 t.d.s.

September 7.—Bilious attack four days ago, and again to-day. These were the first attacks since he took the medicine. He complained now of some presbyopic symptoms for which glasses were ordered. Rep. kali bich.

April 7, 1904.—He consulted me for piles and prolapsus ani, and said he had no headaches at all.

November 29.—Return of headaches the last three weeks, better previously. Attacks every four days now. Great lethargy for some hours after the attack. Has no pain in the piles for some months. This was lessened by kali carb. 6. Rep. kali bich. 30.

December 13.—Biliousness improving, no headache since last note. Complaining of gastric symptoms, for which lycop. 30 was ordered.

On February 28, 1905, there had been no return of headache. Not seen since.

I see in Dr. Clarke's dictionary that kali bich. is specially suited to fair-haired, fat persons, especially fat, chubby children; fat, sluggish people. In my experience most of those in whom I have found kali bich. indicated for bilious headaches have been dark subjects.

I will pass on now to sanguinaria and illustrate it with—

Case 4.—C. A., aged 27, who came to the hospital, December 7, 1901, complaining of sick headache and backache, from which she had suffered for eight or nine months. Attacks begin on waking with frontal headache, which gets worse as the day goes on till night. Vomiting begins in the afternoon of the first day and lasts till the next day. The headache is of a throbbing character, but she has to lie in bed with it; cannot hold her head up. Attacks last three days, and on the last day the pain sometimes centres over the right eye. Feet icy cold with the headache. The headache occurs once a fortnight, and the least excitement brings one on. Is always constipated. Sang. 3x t.d.s.

December 28.—Is better. Only one headache, which lasted one day only, and there was less vomiting. Rep. sang. 3.

January 18, 1902.—Had had no sickness. Has occasionally wakened up with a headache, which has passed off after taking a cup of tea, which it never used to do. Only one bad attack since first coming. No more backache. Bowels much better. Rep. 12.

This patient has not been to see me again.

In sanguinaria, the typical headache begins in the occiput, spreads upwards and forwards, and settles over the right eye. Increasing from touch, temporal veins distended, and painfully sensitive is characteristic. Cooper gives as a key-note: "If he goes without food, gets a bilious attack." Closely resembling sanguinaria in its gastric symptoms is chionanthus, another liver medicine and very useful for bilious attacks. These two remedies have the following symptoms in common: Great nausea; bitter vomiting; sense of constriction or contraction in stomach, as if something living in stomach; goneness with sick headache (sang.); stomach feels weak and empty (chion.). In both, too, the headache is apt to begin on working, but the head symptoms of chionanthus are scanty compared with the more fully proved sanguinaria, but it has throbbing (in the temporal arteries). Decrease by sleep is given under sanguinaria, and increase by sleep under chionanthus, otherwise there is nothing very characteristic in its head symptoms.

I have several times found this drug very useful for the condition under consideration, but will not burden you with complete notes of any case, as I cannot lay my hand on any very characteristic one. A baker who had suffered for years from these attacks derived great benefit from chionanthus while taking it. In this case the gastric symptoms, great nausea, retching, and vomiting, predominated, and the attacks were preceded by much yawning. They usually occurred weekly on Sundays. In this case petrol. 30 had seemed at one time likely to cure; given on account of the great nausea and the presence of a patch of bakers' itch on the wrist.

Case 5.—On July 10, 1901, M. E., aged 62, consulted me at the hospital for an ulcer on the leg of ten to fifteen years'

standing, with great pain, increasing at night when lying down. The pain was described as if a hot iron were applied. She had also varicose veins, and said she suffered from bilious attacks nearly every week, the attacks being accompanied by nausea and vertigo. Unfortunately, no further details of these attacks were noted, as they were regarded as incidental symptoms which merely confirmed the choice of the remedy. She also suffered from pain in the back dorsal region. In addition to varicose veins I noted a patch of redness over the outer malleolus and two small ulcers. (*Carduus* 2x t.d.s.)

August 21.—No bilious attack for some weeks, and less dorsal pain. The leg is still painful. She has also pain in the region of the heart and in the lumbar region every night, increasing 11 to 12 p.m. *Ars.* 12 was prescribed.

She did not return till July next year, 1902, when the note reads: The leg broke out again five weeks ago. Does not suffer from bilious attacks any more.

A later note, June 1, 1904, also adds, "No bilious attacks now."

I must now pass on to what I called the indirect treatment of these cases, and will mention a few remedies that have been useful in this way. The first case I have to mention in this category you may find fault with as not a typical case of bilious attacks, but rather gastric, but since we are not now considering the exact nature of the attacks, but the constitution of the patient, it does not in the least matter, and the patient at any rate called them bilious attacks.

Case 6.—Miss M., aged 19, consulted me December 14, 1900, complaining of dyspepsia and obesity. Her mother's description was, "She is very fat, but eats nothing." She had been fat since she was 12 years old.

I elicited the following symptoms:—

Head.—Frontal headaches, specially on getting up in the morning—wakes with it; can hardly raise her head. Pain sharp, sometimes lasts all day.

Throat.—Frequent attacks of tonsillitis. Has had tonsils partly removed. The right tonsil is very ragged. (She was in service with an eminent allopathic physician in the West End, who pronounced the throat incurable, and who failed to help her in other ways.)

Ears.—Discharge from both lately.

Gastric.—Appetite poor; never hungry. Likes sour things. At times can eat any food, at other times has pain after all food.

About every two weeks has attacks in which she cannot keep any food down. Sometimes great pain in epigastrium of a sharp or dull, heavy character. Stomach swells very much; has to loosen her things. For the last two months worse than ever.

Bowels.—Takes salts, otherwise no action for two or three days.

Catamenia.—Regular, insufficient, with great pain in the hypogastrium and backache. Pain lasts three days. Legs ached during catamenia.

Respiration and Circulation.—Short of breath on stairs. Lips pale when she hurries. When she cuts herself the blood is "watery."

Generalities.—Never feels strong and well. Cuts fester and are slow in healing. Liable to swelling of the eyes and ulcers of the eyes. Sometimes wakes with swelling of the upper lip. Hands clammy; spoils needles. Feet not cold, but damp. Sleep very heavy as a rule.

Skin.—Since infancy liable to "heat spots" on face, blotches and pustules. Perspires very much winter and summer. Feels both heat and cold very much.

Three medicines occurred to me for this patient: calc. c., nat. m., and hepar, the latter two especially presenting strong claims. I chose hepar, and gave 30th potency, a dose to be taken every fourth day.

January, 1901.—Is better. Bowels acting naturally. No more "bilious attacks." Flatulence still occasionally. Upper lip cracks in the centre in cold weather and bleeds. Catamenia no better. Is rather more short of breath, and her right foot is very cold, always colder than the left. Rep. and puls. added, to be taken every two hours during catamenial period. She was seen twice in March for cold and sore throat and cough, for which bry. and phos. were given, followed by hep. 6, on March 9.

April 1st.—Feels better than she ever did. Has had four bilious attacks since January, but none for at least two months. In other words, she had four attacks in three and a half months instead of one a fortnight, and great general improvement. Though I have no further notes, I know she kept well for some considerable time at least.

The prescription in this case was based on the general and skin symptoms practically. Hepar meets the urticarial tendency even to the extent of angio-neurotic œdema, and the swelling of lip I regarded as of that character.

The next case I wish to mention is—

Case 7.—F. M., aged 10, who came to out-patients' department February 4, 1905, complaining of pain in the back, right side of chest and arms. Is very delicate; perspires very much at night on chest and in palms. Is very chilly; always thin; appetite very poor; likes bread and butter and cocoa; dislikes milk, eggs, greens. Comes home faint from school. Gets bilious attacks once or twice a month, commencing with epigastric pain, retching, vomiting and headache. Is very pale and cannot hold his head up during the attack. Tosses about at night, P.E. negative. Is thin; feet cold. Calc. c. 30 t.d.s.

February 18.—Better; bilious attack ten days ago. Last night, headache with vomiting. Faint only once. Less perspiration. Pain in side once. Rep., o.n.

March 4.—No bilious attacks; no pain in side; feet less cold; less sweat; still restless at night. Rep. 200, seven days.

April.—Bad bilious attack a week ago; headache twice; less faintness; feet warmer. S.L.

May 3.—(Seen by Dr. Lewin.) Better; no headache and no bilious attack; appetite no better; sinking in morning; restless and hot at night; throws the clothes off. S.L.

June 3.—Bilious attacks much better. No faintness lately; very hot at night; sulph. 30, o.n. for a week, then S.L.

July 8.—One bilious attack. Headache last Saturday; appetite better; no pain in side now; still restless at night. S.L.

September 2.—There was a slight relapse. Since last seen two months ago, three bilious attacks, and appetite not so well again; no pain after food. As he had now had no medicine except a week of sulphur for five months, he was again given calc. c. 30 once a day.

He has not been to see me since. It will be noticed that after three or four weekly doses of calc. c. 200 there was one bad attack, and then none at all, and no headache for three months, and some general improvement.

The next case is interesting because the bilious attacks in this case were relieved without my knowing of their existence.

Case 8.—J. B., aged 42, came to hospital March 30, 1901, complaining of constant headache and very bad constipation. The headache was described as a dull pain in the forehead, temples and occiput; often wakes with it. He had right abdo-

minal pain and a dull gnawing in the epigastrium after food; much flatulence; bowels very constipated; no inclination at all; stools thin and hard as a rule; straining even with a soft stool. On examination, some tenderness was noticed at McBurney's point, and a sense of resistance in right lumbar and iliac region. For these symptoms alum 12 and later 30 was prescribed, and on April 27, 1901, the bowels were noted to be regular, and remained so till November 30, when nux was given for other symptoms. On December 28 he complained of having had a bad bilious attack ten days previously, and he added that he used to have them frequently one or two a week, and seldom two weeks without one, till he came here, after which he was free from them for nearly nine months. He has only attended a few times since.

This case shows how a medicine may help in an unexpected way.

I have not attempted to cover the field in either group of remedies, especially the latter, which includes certainly all the antipsoric remedies and probably also the nosodes.

Dr. HAWKES (in the chair) thought the members were much indebted to Dr. Lambert for bringing his cases before the Society. If it had fallen to any member's lot to be successful in treating cases, especially common in women, which compelled recumbency for twenty-four hours, and abstinence from all food, he would be glad to hear what treatment he had adopted.

Dr. CLARKE said that Dr. Lambert had mentioned kali bichromicum and its temperament. The author was quite right in saying that kali bichromicum would cure dark people as well as fair. The question of temperaments in remedies was only one factor in a case, and too much was not to be made of it. He thought Dr. Lambert had adopted the right principle in dealing with his cases. In a case that presented very definite indications for a definite remedy, such as kali bichromicum or iris, much good would be obtained from the remedy; but he found in the majority of cases that the best results were not obtained from prescribing on the local symptoms, since nearly all the remedies in the *Materia Medica* had bilious attacks in one form or another. He generally endeavoured to match the temperament. He went into the history of the case, found out, if he could, which miasm was at work, and then selected the particular antipsoric that was called for, or one of the other miasmatic remedies that had

found such a valuable place in the *Materia Medica*. One remedy of great constitutional value was thuja. Most of the people of this country were poisoned more or less with tea, for which thuja was a splendid antidote. A lot of cases could be cured if they were put on a course of thuja, not necessarily at the same time stopping the tea. Most of the people of this country were also poisoned more or less by vaccine, and he found that thuja was more valuable in those cases than any other remedy.

Dr. DYCE BROWN said in his experience patients who came complaining of bilious attacks were not suffering from biliousness, but from essentially nervous attacks. Nine cases out of ten occurred in women, and it was invariably found that the women were of the neurotic type, who had been working themselves beyond their strength, the result being that so-called bilious attacks came on about the time of menstruation and half-way between the menstrual periods. The ordinary treatment of such cases was useless because it was entirely wrong. Physical rest was absolutely essential as part of the treatment. The most useful medicines were sulphur, nux, sepia, actea, kali bichromicum occasionally, and during the severity of the attack iris, which he generally gave every half hour during the attack. Distinct bilious attacks could not be mistaken, and required special and different treatment. Most of the patients who suffered from bilious attacks required dieting; they invariably were over-fed, dyspepsia and constipation occurring as a result. Real bilious attacks were, comparatively speaking, exceptional. It was especially important that people suffering in such a way should eat less than they did, and have the idea removed from their minds that eating as much as they possibly could would help them, whereas it was the occasion of the occurrence of their attacks.

Dr. STONHAM said he was not so disposed to quarrel with the term "bilious" as Dr. Dyce Brown had been, because it was not very easy to separate the two kinds of attacks. There were attacks which were primarily nervous and others which were primarily gastric, but he thought it would be found that the great majority of them had both elements. The remedies which were most useful, such as sanguinaria, iris, kali bichromicum, and nux vomica were all distinctly gastric and liver medicines, and as they cured, it was probable from that point of view that most of the attacks had a gastric or liver origin. He thought bilious attacks, as a rule, were due to the action of a certain poison in the blood, some kind of ptomaine resulting from mal-assimilation of food,

some poisoning of the blood which gradually accumulated until a storm arose and the attack occurred. The attack was usually curative of the bilious condition or headache for a given time, until a fresh accumulation of poison occurred in the system. That, he thought, had been conclusively shown, not only by the character of the drugs, which were useful, but also by the effect that dieting had upon them. Many people had been cured of bilious attacks by simply being put on a non-meat or vegetarian diet, a diet in which the particular poisons causing the attacks were not found. Very frequently a large nervous element was present, shown by the frequency with which a large discharge of colourless urine was obtained, which on examination was found to be greatly deficient in uric acid. The uric acid was retained in the system during the attack, and it was not until it was got rid of that the attack ceased. He quite agreed with Dr. Lambert that the use of kali bichromicum was not confined to fat people, but could be used for thin people as well. Kali bichromicum was supposed to be good for people who were beer drinkers, and fat and flabby in consequence. It had that antidotal relation, and he thought it was most useful in cases of this kind where rheumatic symptoms were present.

Dr. LAMBERT, in reply, quite agreed with Dr. Clarke's remarks with regard to temperament. He had tried as much as possible to get an idea as to the kind of patients that certain drugs acted best upon. A prescription could not be based on that only, but it was often very helpful. A doctor with the proper experience could tell as soon as he saw patients whether they were likely to be benefited by certain remedies, such as bryonia, nitric acid, or sulphur. Of course, that could not be done every time; but he believed if the appearances of patients and their temperaments were studied it would be found that certain drugs acted much better on particular patients. Of course, there were exceptions. Dr. Stonham had suggested beer drinking was the cause of the kali bichromicum type, but the same description applied to fat and chubby children who do not drink beer. The cases Dr. Dyce Brown had referred to were evidently quite a different class from those mentioned in the paper. He did not make the slightest difference in dieting the patients or resting them; he had tried to avoid the pathological side and simply take the symptoms. As to whether the condition was due to a poison in the blood or not, he did not care. Probably thousands of other people had the same poison in the blood and did not get bilious attacks. There was some fundamental constitutional basis which rendered

certain patients susceptible to bilious attacks. One of his patients had bilious attacks for twenty-eight years and then had them cured by iris in six months, with no alteration in diet, &c. How could that be put down to poison in the blood? In his opinion, pathological ideas were doing harm. Homœopathy is based upon facts, and is not affected by pathological theories.

Dr. BYRES MOIR remarked that unless the causation and history of the case were considered the results were not worth anything as far as the drug treatment was concerned. If it was Dr. Lambert's contention that pathology was of no use, he in turn expressed the opinion that no conclusion could be drawn from drug treatment until the pathological aspect had been investigated.

MEDICAL TERMS AND UNREASON.¹

BY EDMUND HUGHES, M.R.C.S., L.R.C.P.

Medical Officer to the North Homœopathic Dispensary, Liverpool.

MR. PRESIDENT AND GENTLEMEN,—The habit of clear thinking is more important than the possession of much current knowledge. A man may have a most eminent faculty of acquiring, and of remembering the material of his experience; but he may pass through life without advancing true knowledge by one step. Instead, he may countenance and propagate erroneous ideas. At our seats of learning there are many examples of the admirable faculty to which I have referred. Such do not sin consciously. They may even be lucid exponents in some sort. But their uncritical habit is a constant danger to themselves and others. It is apt to be forgotten that the truly critical—let us say, rational—mind is critical of all things—old and new alike. The mind most actively misoneist is the mind not habitually critical, but here over-acquiescent, there over-dogmatic in refusal, only sometimes well balanced; and unfortunately most critics are of the partial order. Because the scientific spirit is now becoming predominant, our modern schools are

¹ Presented to the Liverpool Branch, January 11, 1906.

not so unprogressive as those scoffed at by Gibbon, and deplored by Goethe. They do not deserve the bitter pronouncement of Schopenhauer on those of his time: "So, too, with academies and chairs of philosophy. You have a kind of a signboard hung out to show the apparent abode of wisdom; but wisdom is another guest who declines the invitation." Modern revolutionary investigators would be received more kindly there than such men as Harvey, Paré, Edward Jenner, and John Hunter. Still, however, there is cant to be avoided. We pass out of such places, perhaps, vain of our glittering new equipment, which with sorrow and disgust we have to throw off in large part along the road.

The wise man of old, being asked what he had found the most difficult kind of learning, is said to have replied, "To unlearn what has been learnt." For this reason error is transmitted with little change from generation to generation. Even if men be urged to "unlearn," they prefer not to do it. But being generally urged not to do it, it is still less likely they will attempt it. The professor dogmatizes and speculates with bland self-assurance. Veneration clears the path like a bribe. We are aware of the existence on all sides of a vast mental inertia, of that unreasoning conservatism of the human race, whose "servile imitancy" Carlyle maliciously likened to that of a flock of sheep.

A conventional misuse of words is the most annoying result of the uncritical habit. Language is a mischievous contrivance. It is to some a snare, entrapping, unconsciously to the victim, nearly all their thought. They fall into it at first, and never afterwards escape from it. Even to the best, language is a barbarous instrument, which has to be put up with, and used with what success it will allow. The difficulties of expression, however, pass unheeded in many quarters. How often we read articles whose titles attract, and find that nothing of value has been written there! It would be a salutary check on some speakers and writers were they required to define their terms beforehand. There would be less rubbish to be thrown away. I take it, the only way out of *confusion of thought* is to define everything as far as definition can be carried. That is, definition must

be in terms of knowledge, and continued to the ultimate source of all knowledge, *i.e.*, to the evidence of the senses. The writings of a few show that they have followed this method. Such writings are monumental, and one can suppose that the spoken word was also refreshingly accurate and profound in these cases. In the pursuit of truth no verbal licence is permissible. One notices, indeed, a grand effort after accuracy in modern medical books and essays. But there are still a few victims of logorrhœa, so to speak, parading their unfortunate faculty, and voiding forth distressing quantities of verbiage. Between these two notable extremes is a host of writings marked by more or less vagueness and looseness of expression. Sometimes one is startled to find this defect over an eminent signature. Thus, Sir Frederick Treves in a recent essay on movable kidney writes of "its undue mobility practically ceasing with the patient's life." He goes on, "It is not always possible to determine after death if a kidney had been clinically movable during life, except, perhaps, in cases in which the mobility had been extreme." Here the information presumably intended is not supplied. The qualifying words only allow us to conclude that the movable kidney, whose performances are so mysterious during life, continues in some way its romantic career *post mortem*.

Though there certainly are clear thinkers who do not write clearly, no evidence tells us that they *could* not achieve clearness of expression. The inference is rather that they did not take the pains; that they failed to attend to the subject of language, either through sheer pre-occupation, or from impatience to communicate ideas. Nor does the "literary faculty" in any way conduce to clearness of diction, being only concerned with grace, rhythm, and fluency. The *mot juste* of scientific or accurate phrasing is very different from the *mot juste* of the artist in words. It is essentially want of care that causes ambiguity; and the writer who has not considered the snares and difficulties in the path of right expression will almost certainly be taken in by them, though he succeed in making people think otherwise. By this ill-considered writing the community is grievously wronged,

whether aware of the injustice or not; and the progress of thought is retarded. Accuracy of idea and of expression go hand in hand.

A few random examples only can be considered this evening, though a Book of Errors might easily be compiled by any one who has the taste. Dr. Robert Jones¹ upholds the view that "there are diseases of function as well as of organs." His article is written to support this view in the cases of forms of insanity. By the nature of the enterprise, there is here an unusual need of accurate discrimination and a clear understanding of the main words to be employed. Partly realising this, Dr. Jones states, with apologies, his intention of defining his terms at the outset. Having defined "function" (which was clear already), he then says that such diseases as are associated with "no discoverable nervous lesions" are "functional diseases." Next, "these functional diseases, also termed dynamic or vital as opposed to those of a physical or material character, are in contradistinction to organic or lesional diseases." It is readily seen that we are here left with two ideas at least verbally distinct of the same term "functional disease." But, to our surprise, Dr. Jones does no more defining. He is thus condemned to work out his thesis to its stultification.

The dilemma of the position is exactly in that although by the one statement the distinction between functional and organic disease is merely made an aspect of the distinction between the unperceived and the perceived (or the unseen and the seen), by the other it is supposed that in the act of functioning no material change whatever takes place in the system of organs concerned. The undiscovered is made synonymous with the undiscoverable in disease. We can have a disease affecting an abstract idea; and must acknowledge a transcendental pathology.

All this is an attempt to frame a positive hypothesis upon negative evidence. Thereafter the writer tacitly admits that the undiscovered need not be the undiscoverable. This fact, however, only hinders his point of view; and in his attitude as special pleader he should not have let it

¹ "Functional Insanity," *Practitioner*, May, 1905.

appear. Nor does the following statement help him. He says: "Observers have been content, in the absence of definite lesions, to describe mental abnormalities as 'disease manifestations,' but not disease, *i.e.*, that the mental states or conditions are functional, and not due to structural or organic changes." Here, again, is a confusion of ideas, in which Dr. Jones almost seems to share. At all events, the distinction introduced is clearly an artificial one, and it is alarming to hear of anybody being "content" with it. A manifestation of a thing is precisely the sum of the tests which we apply to prove the thing's "reality."¹ If a thing be not present, it is not manifested; if manifested, it is present. A thing may seem to be manifested without being present, but only by a hasty judgment on insufficient proofs.

The point which Dr. Jones thus evades has been still more recently referred to by Dr. Henry Ashby.² Speaking of the difficulty in the use of the terms "functional disorder" or "neurosis" in connection with the child, he says that he must risk criticism, "bearing in mind that there are no hard lines in the classification of disease, and great comfort in taking refuge in the word 'borderland.'" This, too, though comparatively a candid statement, neglects the real issue, which is not in "hard lines in classification," but in the distinction between the word "functional" and its idea, and the word "organic" and its idea—for the purpose of classification. One may require new and more accurate terminologies without impugning the general statement that rigid distinctions are not possible.

It is seen that Dr. Jones' brilliant essay loses all its point through an insufficient definition of terms. Had he defined the words "lesion" and "disease" (to take two out of several); had he offered to explain to us the opposition between "material" and "vital"; he would have found it necessary either to abandon his thesis altogether, or at least to restate it in rational form.

Another example of this class of error occurs in the same

¹ That is, presence in relation to ourselves.

² Wightman Lectures on "Some of the Neuroses of Early Life," *Lancet*, July 22, 1905.

paper. It serves as well as any other for my purpose. Dr. Jones, speaking of cortical areas, says: ". . . this region physiologically is, therefore, the most highly developed, the least organised, and the most complex of all the cortical areas, and, in consequence, the most likely to be disturbed by adverse stress."

Now, the scientific use of the term "degree of organisation" shows it to mean more than what we understand by degree of stability in the case of chemical compounds. Degree of organisation is concerned also with the number of working divisions in an organic entity. ["Lowly organised" is, we know, applied to an animal or plant, because its functions are performed by relatively few and simple organs, *e.g.*, to an animal without specialised sense-organs, or having a common cloaca for genital secretion and excrementa.] A confusion of ideas therefore results from the description of a healthy working division of the human brain as "least organised." A similar confusion attends the use of certain other terms. The term "irritation" may read "normal action," "over-action," "reversed action," "inflammation," "itching," "loss of cerebral inhibition." (See also Hoblyn's Dictionary; *Irritation*; Ed. 1899.) Nothing could be much vaguer. Yet, quite apart from the use of "irritation" by the physiologist as an alternative to "stimulation," of a nerve or nerve cell, no term perhaps enjoys a freer currency in medical prose. Space forbids any accumulation of references. One may allude in passing to a report of a paper by Dr. Davies, of Bristol, on the use of isolation hospitals,¹ where it is said that "the diphtheria bacillus is too delicate an organism to live in drains or in filth heaps." Disregarding the possibility of humorous suggestion, as that the Klebs-Löffler bacillus is a microbe of refinement, and figuratively holds its nose before a bad smell, we have but to fall back on the various meanings—primary and derived—of this curious word "delicate" to realise that the statement is frivolously inappropriate.

The thoughts which are aroused by a close consideration of the subject of terms must clearly be relevant and

¹ *Hospital*, June 10, 1905.

important to our great science. The question has two aspects, but the one is far outweighed by the other. There is powerful advocacy for a free use of language. There is the warning against the rigidity of definitions. There is the identity and symbolism of all Nature, dwelt upon by Emerson, and others of his stamp, and presented with inexhaustible fertility by Shakespeare in poetic figure. There is the mental groping after an explanation of things, and the presumptive obligation to the use of terms that lie ready to hand. But from the other aspect, common logic urges us to great caution in the naming of phenomena, now so heterogeneous that the mind has to grasp them as distinct and widely separate. Moreover, the obligation above noted is, I contend, largely fancied; and the habit it engenders serves not only to confuse thought, but to blunt the edge of enquiry. The fact, generally, is that the more we know of a subject, the more terms do we use to explain it to ourselves, and the more precise becomes the meaning of each term. In accurate thinking, words, moreover, have their categories, and must not be used out of them. Familiarity with a word in its popular use renders it very plausible and seemingly expressive when put to the purpose of scientific exposition. The result, however, may be an unfounded assumption of knowledge. If the nature of a reality be confessedly unknown, the confession acts as a perpetual spur to research. But we shrink from this salutary admission of ignorance. We would rather be at compromise with truth.

It is only a literary weakness which prefers a graceful exposition in popular language of subjects half known and demanding in their treatment the strictest accuracy both of thought and phrase. We reach here a condition of sheer intellectual failure. I venture, in conclusion, to suggest the need for an expurgation and purification of our current terminology. That this is really called for, no one who reads the various literature of medical science with a critical mind will care to dispute.

The problem of terms has been presented first, because it is the very foundation of the subject I have in hand, of which other sections may now be as briefly considered.

The inconclusiveness of much of our work is apt to escape attention, and indeed is not easy to keep before the mind. Though only fanaticism could entirely ignore a reflection so uncomfortable, it is to be inferred that many entertain it only, as it were, in lucid intervals—at times, perhaps, when the stress of work is withdrawn, and the mind has leisure to cope with general problems. Any much indulgence of this topic, in fact, might seriously affect one's pocket. The highest reason, however, forbids us to assert in *most* cases either that the patient would have died without medicinal interference, or that he would have made a less speedy, a less complete, or a less permanent, recovery than was the case after our medicines had been applied; or that, in other instances, a disease he might have had was prevented by medicine, or, if it had already started, that medicine had "aborted" it. We can seldom be *confident* that a seeming success was not fancied. Concerning chronic diseases of vital organs, when do we *know* that we have stayed the sentence of death? Some drugs probably get into the textbooks under false pretences. It is noticeable that when any one gets up and praises a drug for a certain disease, there are often dissentient voices. In *most* cases, I repeat, the efficacy of medicine in our hands is only apparent, and in those cases, therefore, to believe in its efficacy is to commit ourselves to those two potent generators of fallacy—conclusion *à priori*, and the argument *non causa pro causâ*. Let us take comfort in that we only lay ourselves open to fallacy, and do not necessarily commit one. The fact, indeed, has no warrant to induce the high degree of scepticism it sometimes does induce. It mainly serves to emphasise the need of greater exactitude in our judgment of comparative results, and, in fact, of a surer basis for practice.

Critics of the foregoing would possibly object that experience is a good enough guide. One remembers the saying of Thomas Hobbes, that in sickness he would rather have the attentions of an experienced old woman than a learned young doctor fresh from the schools. Any one can gather how much and how little is implied by such a saying. Mere experience, of course, has no special sanction to decide in the

subjects here being considered. It has to defer to those experimental tests, which offer the only genuine criteria. If it fails to do so, a long and wide experience may cause rooted convictions, which it imposes as if by authority, though these convictions have arisen, not from a rational process, but from long habit, and strengthened by much thinking in the direction indicated by bias.

To counteract this failing, much play is made with statistics. And it is a serious consideration that the least inaccurate method of estimating for treatment, &c., which we possess should often be debased by unworthy usage. One is distressed by that common and pernicious mistake of reducing lesser numbers to 100, and then drawing up "percentages." How frequently, also, one reads argument which supposes that results obtained for a particular series apply to all series in that category. Moreover, whatever opinion is entertained of the value of any mode of treatment, no one is justified in telling a patient that he has so many chances in a hundred of a successful issue to his case; though the error is apt to be committed—by those, it might be imagined, who have had no dealings with the turf. Would that we could tell! This is like the diagnostic mistake of excluding a disease from consideration because of its rarity. One is told of the surgical operator who would scratch his head after elaborately disinfecting the rest of his person. Such is an error that mars a close train of observation and inference.

The argument from figures sometimes has cogency. But before figures can be rationally valued, they evidently need to be subjected to close criticism. The subject requires some preliminary study; and I submit that the essential part of this study must be devoted to the subject of diseases themselves, not to statistics in general, nor to mathematical theories of probability. In this way, after accumulation of numerous facts, some guarded estimates may be made. The question on which a judgment of medical statistics will turn, is whether the unavoidable errors in the method employed are great enough to nullify its results. Difficult as the subject is, I suppose it may be granted that where the

results of experiments so conducted as to exclude avoidable error show a discrepancy of, say, over one in five, they may be accepted, with some allowance, as affording a trustworthy practical guide. There may be a lawful dispute about the exact numerical discount for unavoidable error. No exactness is really to be expected, and the extent of error will differ with the degree of difficulty in the research.

The introduction of avoidable error is not merely allowed and disregarded, as we have noted, with deplorable frequency, but it often renders painstaking experiments inconclusive; as where an accurate series is compared with inaccurate or differing ones. It is not needful to classify the various avoidable errors which may and do occur. Let us glance at the sources of unavoidable error for which allowance must be made. We are comparing, say, two or more series of cases to ascertain the best plan of treatment. If the cases are taken at random, there is ignorance as to the relative proportions of the different classes of case (varying probably with the patient's degree of protection by natural selection), that is, ignorance as to the proportions of degrees in what may be styled "natural severity." It is infinity to one against these proportions being identical for all series. But it will be seen that if seeking to obviate this we try to choose cases of like natural severity, we encounter the insurmountable difficulty of knowing beforehand what the natural severity will be for any individual, since even in the same family or stock degree of natural immunity is not the same for all members. It is no solution of this difficulty to wait till the patient is moribund or convalescent. The problem is widened when the complications of the disease, and when the patient's constitutional complications, are taken into account. When we have to estimate for a patient's inherited tendencies, for his habits, for the impress of past disease—matters which make correspondence in mere age an almost futile precaution—we realise that the labour of doing so is alike intolerable and useless.

The fallacies inherent in the various methods of estimating for general rates in the total population of a country are not so great as to vitiate the result. The possibility

of error would be indefinitely increased, however, in such estimates were they based on figures for a few out of the total number of districts involved. The probability of a truthful average would vary, roughly speaking, in direct proportion to the number of districts taken into account. Yet, for many diseases we are asked to accept figures thus doubtfully computed. We are committed to results from *particular* series, here and there, variously gained, and under non-representative conditions of life and climate. At present the error thus admitted is unavoidable. Hereafter, if all disease should become registrable, there will probably be found large discrepancies between present-day estimates and those gained by a relatively thorough method then possible.

The fact that now there are no reliable average figures (of mortality, &c.) for many diseases prevents definiteness regarding the merits of different modes of treatment for these diseases. The most conflicting opinions are consequently formed, and everyone follows his bent without gainsaying. The labour of *comparing* series of cases, and the labour of obtaining *large* series—the latter increasing the former, the former discrediting the latter—these create a distrust of figures, and towards innovations a scepticism which, for aught we know, may be a most important hindrance to reform.

In the light of what has been said the principle of treatment of disease by “similars” admits of some just criticism. I have no wish to classify this principle as the outcome of “medical unreason.” The subject of homœopathy (so-called) needs, however, the same searching analysis by which we test other objects of an accurate attention—analysis which its opponents will seldom give, and which even its supporters do not seem to have at all consistently undertaken. What small knowledge I possess allows me even to assert that they have not undertaken it. Yet the status of a method still ignored by the bulk of the profession is so precarious that it needs as much demonstration, if we accept its value, as any assertion of new and revolutionary doctrine. It needs, in fact, evidence of unusual and convincing force. I think it not improbable that if “homœo-

pathy" had from its outset been attended by a great accumulation of such evidence, it would not have struggled so long for general recognition. Now, disregarding the possible weapons and tactics of past controversy, let us suppose a fresh debate to take place. We can suppose the "homœopath" exhibiting his great natural law, making his allusions from the ancients, dwelling on the relative simplicity of the method in theory and practice, giving the conclusions of much experience here and there, and even buttressing his defence by illustrations derived from the data of molecular physics. The "allopath," on the other hand, will say: "You have told me much that I already acknowledge or will now admit; but you give me very little exact fact. The figures you adduce are striking. But do they come under the head of accurate statistics? Where, in short, are your infallible proofs? You have said little that appears as scientific evidence. Nor have you properly weighed against your system the claims of our manifold therapeutic means with which that system, unless it acknowledge their superior efficacy, must needs contend. You have made your assertion: on you lies the onus of proving it. But in taking a badge, you really seem to have accepted a prejudice."

Most of us acknowledge the superiority of our method in the belief that the evidence in its favour does preponderate. And it is important that the field covered by drug action under it includes, in some cases, the province of orthodox specialism, with which, therefore, the method must conflict. Under all these circumstances, how is it that the would-be learner of "homœopathy" has only his own experience to depend upon, aided by numerous collections of more or less fallible opinions? Quite apart from mere repertories, which have no reference to standards of value, he can consult no satisfying body of fact. I lately picked up Dr. Burnett's "Fifty Reasons," still in circulation, and found them, to my surprise, based on the records of merely about fifty cases. Had they been five hundred he would not have had a rational success. It is rational success that we want. The younger members of our associations especially should be sure that they are not merely echoing a shibboleth.

And, under present conditions, bearing in mind the intellectual demands of abler students of to-day, it is not astonishing that we have to deplore a lack of recruits.

This leads us for a moment to the relatively high dilutions. The late James Braid, reflecting that a patient would have to take his dose—a grain of an attenuation, approximately the 6th centesimal—every second of the day and night for thirty thousand years before one grain of the pure drug had been received, attributed any apparent efficacy of the infinitesimal to unconscious suggestion. This may be an absurd conclusion; it remains, however, still to be refuted. If this method is to stand, its rational defence should be constructed. Evidence is wanted which—as evidence—the scientific mind cannot easily repudiate. Since here, also, the claims made are unusual, they demand evidence of unusual strength. Till that is forthcoming, an attitude of scepticism should surely be maintained.

The field we have briefly surveyed is clearly of much importance. Few but admit—few at least escape—the difficulty of never pandering to the ignorance and superstition of the laity. This personal factor at once hampers and ennobles our science, under the peculiar conditions of which it is often easier to seem scientific than to actually be so. We are probably agreed, moreover, that the scientific standard shown by our prominent medical journals is only the “high-water mark” for the profession in this country, and does not represent its average standard.

So that though a review of these problems may be to many of us superfluous, it is sometimes well not only to remember that such problems exist, not only to discuss them, but to realise that for many a man their existence must constitute a lifelong barrier to true intellectual success.

SOCIETY NEWS.**NEW MEMBERS.**

At the meeting of the Society in March the following gentlemen were elected members of the Society :—

James Eadie, M.B., Ch.B.Glasgow, of 7, Upper Woburn Place, London, W.C., and

Thomas Henry Barnes, M.D.St. Andrews, M.R.C.S.Eng. L.S.A., of 148 Lavender Hill, London, S.W.

OBITUARY.*Edward John Hawkes.*

Dr. Hawkes, of Ramsgate, was elected a member of the Society in 1888. It was with deep regret that his death was announced as having taken place suddenly from aneurism on January 22 last, at the age of 62. Dr. Hawkes' predominant characteristics were a broad-minded humanity and geniality, and these he put into everything he engaged in. His geniality passed over into fun and humour, and his presence among his friends will be sadly missed in these directions. His professional forte did not appear to be research or literature, but rather good medical practice and hygiene. In these latter he did much for the town in which he lived, and indirectly for the cause of homœopathy. His sympathies were strongly with the welfare of homœopathic institutions, the Hospital, the Society, the Congress, the Association. These central bodies could ill afford to lose such a worthy country representative.

SUMMARY OF PHARMACODYNAMICS AND THERAPEUTICS.

*Extracted from Exchange and other Journals by the Editor, in
collaboration with J. Galley Blackley, M.B., and T. G. Stonham,
M.D.*

Aconite.—Some interesting cases of the use of “aconite in its less common aspects” are published in a paper by Dr. Spencer Carleton. The first is a case of intermittent fever of five years’ standing in a woman, aged 74. She had been under all sorts of treatment during the period of her illness. Paroxysms came on every seventh day. Plasmodia were plentiful. She was seen tossing about the bed in much anxiety, one cheek red, the other pale. She *had* to move, but every time she moved a rigor would pass up the spine and the face would become pale. She had a loose cough, and not a high fever, but a long-lasting subnormal temperature; also profuse sweat, bitter vomiting; chill began in the feet. Bright red hypothenar eminences. The case suggested nux, arsenicum, lycopodium, chamomilla, aconite. Aconite 200, one dose a day after the paroxysm, completed the cure in a week. This was two years ago. She has been well ever since. The second case is one of religious mania, alternating with melancholia, the patient being a hypersensitive young woman, aged 22. The chief mental trouble was fear of discussion of religious topics; also fear of loss of reason and memory; fearful hallucinations at night; fearful dreams; cannot bear music; fear of crossing a street, of falling buildings, and sharp projectiles; alternation of moods from extreme gaiety to sadness. Aconite 1 m. ended the whole matter, the ungovernable fear being the distinctive indication for it. A third “less common” use of aconite is in injuries to the cornea, particularly if a foreign body is embedded in it. Dr. Carleton infers that aconite assists the ejection of the foreign body. Also it is useful in states of congestion of orbital structures after injury, especially if the symptoms of shock point to the remedy.

A discussion, reported by Dr. Guy B. Stearns, followed the reading of Dr. Carleton's paper, in which instances of the following diseases were cited as being cured or markedly improved by aconite: Injuries to eyes, traumatic neurasthenia, neurasthenia from grief, paroxysmal cough, rheumatism with marked nocturnal aggravation and intolerance of pain, chronic bronchorrhœa, phthisis with frequent hæmorrhage, neuritis with burning and stabbing pains, angina pectoris, rectal neuralgia. (*North American Journal of Homœopathy*, January, 1906, p. 19.)—Ed.

Belladonna.—In “a practical study” of belladonna, Dr. P. W. Shedd gives the following excellent general summary of the sphere and action of belladonna: “Belladonna, in contrast to aconite, which acts directly upon the circulatory apparatus, affects first the nervous and then indirectly the vascular system, its action being centrifugal. Of the nerve centres, the highest or brain cortex, bulb, meninges, medulla, are first involved, then the lower centres and the great sympathetic. Thus we find belladonna pains proceeding from above downwards. It congests and irritates neural tissue, and exhibits the phenomena of disordered function. Its neuritis, for example, is due not to a structural change in the nerve tissue, but to an inflammatory irritation. Belladonna relaxes physiologically all sphincters, *e.g.*, iris, paralysing the endings of the third nerve, thus allowing the iris to dilate, and destroying the power of accommodation. It is rapid in action, forming one of the quintette, aconite, belladonna, cuprum, nux vomica, and zincum, which act quickly when indicated. A characteristic toxic syndrome, which sketches roughly its homœopathic range, is “a dry mouth and fauces, difficult deglutition, constrictive spasms of mouth and fauces, mydriasis, loss of accommodation with obscured vision, optical illusions (phantasms), suffused eyes, ringing in the ears, numbness of the face, vertigo, delirium, scarlet eruption, sopor” (Hempel). It is suited to robust, plethoric, somewhat phlegmatic individuals inclined to obesity, of a Falstaffian temperament; of a candid, open character and good cerebral development, who, when sick, are suddenly and exceedingly sick, the acute cerebral hyperæmia being the veritable response of a vigorous nature to the disease (or drug) stimulus. Calc. carb. is the chronic of belladonna, and often completes its action, and should be studied when belladonna, though indicated, fails. Belladonna is the acute antidote, calcarea carbonica the chronic antidote of lachesis. Atropine, the alkaloid, has more neural action than belladonna. A hypodermic

of atropine antidotes the physiologic effect of opium, morphine, hydrocyanic acid. Belladonna is a right-sided remedy, but only characteristically so in subacute or chronic complaints, *e.g.*, a recurrent right ovaritis, or angina, with other belladonna symptoms. In acute cases it is suitable to complaints (with belladonna features) on either side of the body. (*New England Medical Gazette*, January, p. 1.)—ED.

Cinchona. *Effect on Gastric Secretion.*—MM. Nano and Merouesco have been testing the influence of various "bitters" (chiefly tincture of cinchona) upon the secretion of hydrochloric acid in the human stomach. The results were especially marked in cases of hypochlorhydria. A test meal was first given, and after an hour the stomach was emptied and the hydrochloric acid estimated. On the following day the same experiment was performed after having first administered twenty to twenty-five drops of tincture of cinchona. The percentage of hydrochloric acid showed a notable increase.

In one case the authors found on the first day 0.183 per 1,000 of free acid and 0.604 total hydrochloric acid; after the administration of the cinchona the figures were 0.735 per 1,000 of free acid and 1.470 per 1,000 total hydrochloric acid. (*L'Art Médical*, January, 1906, p. 55.)—J. G. B.

Grindelia Robusta.—Dr. Cowperthwaite says this drug paralyses the muscles of respiration through the pneumogastric, and that he has seen it relieve Cheyne-Stokes respiration in a very short time. Its chief indication in all respiratory troubles is that the patient cannot breathe when lying down. Stops breathing when falling asleep; wakes with a start and gasps for breath. (*Medical Century*, September, 1905.)—T. G. S.

Hypericum in Numbness following Operation.—Dr. Stiegele, of Stuttgart, relates the case of a man, aged 24, who came complaining of sensation in his right arm. When 16 years old he had had an inflammation of the right elbow-joint, which was followed by chronic suppuration. This was treated by operation. Since last spring he had felt a buzzing in the right arm up to the finger-tips, especially in the thumb and ring finger, and a sensation of formication. These symptoms were continually present. An examination showed only a slight ankylosis in the elbow-joint. Hypericum 3, five drops, three times a day, was given. In a week he had felt great relief. In two weeks the

sensation had entirely ceased. (*Homœopathic Recorder*, November, 1905.)—T. G. S.

Infantile Scurvy.—Dr. Roberson Day publishes a case of infantile scurvy, which shows the rapid improvement which sets in when the patient is put on "fresh food" diet. Dr. Day styles this disease "patent food disease." The patient was a girl, aged 11 months, who had the left eye protruding from the orbit, and the eyelids red and ecchymosed. A bottle-fed baby, and taking Savory and Moore's food and Nestlé's milk for six months. The eyelids were swollen and of various colours, like bruises. The vaccination marks were hæmorrhagic; there were punctiform hæmorrhages on the palate, and round the lower incisor teeth the gums were smaller and darker than usual. There was tenderness of the left leg. The ribs were markedly, with the rosary and the epiphyses, much enlarged. Anæmia was pronounced. Patient could not sit up alone. She was put on calc. carb. 6, with grape or orange juice, and fresh nursery milk; sea-salt spongings were given. In a week she was very much better, the proptosis had subsided, and she could sit up alone. The improvement continued. (*Monthly Homœopathic Review*, February, p. 74.)—Ed.

Iodoform. Poisoning.—Stauffer, of Munich, relates the following symptoms observed in a patient, aged 70, suffering from vesical catarrh, and whose bladder after being washed out daily received an injection of emulsion of iodoform. When first seen late at night he was in a state of high nervous irritability, could not sit still a moment, got up and raced round the room, spoke much, and was exceedingly impatient. Said he had not closed his eyes for eight days and that the nights were much more restless than the days. He went to bed tossing from side to side; striking a light, reading for a while, then putting out the light, getting up and walking about again. He complained that in the day-time he could not exercise his intellectual faculties as usual, as he was unable to concentrate his thoughts; and during an interview he jumped constantly from one subject to another; suffering meanwhile from severe headache over the whole calvarium, with loss of memory; was much depressed; had thoughts of death, and was at times quite melancholic. Appetite was quite in abeyance; breath fœtid; tongue dry, with sticky sensation, much thirst, frequent small mucous stools. Heart's action much excited; pulse 120, heart sounds pure.

After leaving off the use of iodoform and taking arsen. alb. 5 as

antidote, the patient had three more nights in a state of considerable excitement, the urine smelling all the time strongly of iodoform. The fourth night, however, was very good. (*Allg. Homœop. Zeit.*, January 25, 1906, p. 22.)—J. G. B.

Lobelia Erinus in Malignant Disease.—A gentleman, aged 75, suffered from a small, solid, purple-coloured growth under the right eyelid, which was removed by operation. The wound healed well, but the resulting scar caused ectropion, which was treated by a plastic operation. For some time a small swelling had been noticed inside the right cheek, which now rapidly increased in size, accompanied by a good deal of pain in the swelling, with severe attacks of neuralgia up the side of the head over the right parietal region. The tumour was diagnosed as epithelioma too extensive for operation. The tumour could be freely moved over the bone through the cheek, but was adherent to the skin. It measured $3\frac{1}{4}$ by $2\frac{3}{4}$ inches, with infiltration round. There was cutting, stinging pain in the scars under the eye; also burning in the internal surface of the tumour, especially felt when touched by the tongue. The cutting pain lasts about half a minute and varies in intensity. This pain is in addition to the neuralgia above mentioned. Morphia had been given to ease the pain. On November 28, 1903, Dr. R. M. Le H. Cooper began treatment by a single dose of lobelia erinus ϕ . Morphia was stopped, and restriction placed on the diet with regard to meat and salt. On December 17 there was no pain in the tumour, that in the scars remained; the tumour was no larger; mag. carb. 200 was to be given if pain was severe. On December 30 the pains round the eyes were less, and the tumour had diminished one third. On January 20, 1904, a similar report; size of the tumour 1 by 1 inch; the lobelia was repeated. Four months later the tumour had gone, and a year and a half after there had been no recurrence. (*Homœopathic World*, December, 1905, p. 539.)—ED.

Magnesium Salts. *Experiments on Animals.*—Dr. J. S. Meltzer, of New York, announces results of intracerebral injection of sulphate of magnesium in the rabbit. Speedy paralysis ensues without antecedent convulsions. Subcutaneous injections of a 25 per cent. solution produces in a short time a profound anæsthesia lasting from one to over two hours. It was possible to perform various operations. Similar results were obtained with magnesium chloride and bromide. There was no precedent period of excitation, anæsthesia appearing to be a primary effect. When applied

to nerve trunks these salts inhibit the power of conduction of both motor and sensory impulses. Intrapinal injections were made with similar results. (*Medical News*, December, 1905, quoted in the *Therapeutic Gazette*, February, p. 126.)—ED.

Natrum Sulph. in Hepatic Disorders.—Dr. Luther T. Gill, of Cubsinburg, Ohio, points to natrum sulph. as a valuable remedy in hepatic disorders where there is conclusive evidence of abnormal secretion or excretion of bile, and gives illustrative cases. (1) A woman, about 50, gave, as a history, the recovery from a sickness which was diagnosed as malarial fever, with subsequent onset of pain, distress, and, later, a feeling of tightness in the region of the liver accompanied by obstinate constipation. Constant vomiting and exhaustion ensued, with much emaciation. No solid nourishment had been taken into the stomach for seven weeks, and all fluids had been vomited. The face had a yellowish, dry, shrivelled look. Over the liver there was a constant severe pain, and always distress or tightness. There had been no evacuation of the bowels for a week, and during the preceeding five or six weeks only very small quantities of dry brown fæces at long intervals. There was little or no general jaundice. Flushing of the bowel with warm water was resorted to at first, then rectal feeding for a week, and natr. sulph. 3x tablets, $\frac{1}{3}$ gr. in water, every two hours. Vomiting ceased in two days, the patient began eating in eight days, and made a good recovery. (2) Another woman, aged 50, had had several years of periodical attacks, three or four a year, and was gradually getting worse. Early one evening she was suffering intensely, abdomen much distended, some nausea, with ineffectual attempts to belch gas. She was in a cold perspiration, pulse quick and weak. The character of the pain was as if the stomach would burst. The heart's action was interfered with, and the case looked grave. Magn. phos. 3x in hot water relieved the pain immediately, and much gas was emitted. Former and lighter attacks had been relieved by copious vomiting, which would be followed in about twenty-four hours by slight jaundice, and still later by a few loose evacuations from the bowels. Two or three days previous to the attack the patient would feel dizzy, or dull in the head, with slight constipation, but with no unusual stomach symptoms. Natr. sulph. 3x was given twice daily for two weeks. One more slight attack occurred two months later, but none afterwards (two years). A dose or two of natr. sulph. is taken if any of the premonitory head symptoms show themselves. (*Cleveland Medical and Surgical Reporter*, February, p. 47.)—ED.

Nux Moschata. *Poisoning.*—Dr. A. Norris Wilkinson (Bright, Victoria, Australia) writes: The following is a short account of four members of a family who took nutmeg: In mother and son it produced a narcotic effect, but in the two girls gave rise to choreic symptoms, the former action being as given usually in the text-books, the latter the converse. I was called to visit M. L., aged $4\frac{1}{2}$, who, with her elder sister, six days previously had eaten or chewed nutmeg nut; they had been given potassium bromide in mixture by the local chemist, but as one had not improved, but was much worse, he had advised them to call me in. The history of the symptoms up to that day, given me by the mother, was that there had been no vomiting. On the day after taking the nutmeg she “spat frothy spittle”; there was no purging; she slept peacefully, but there were movements of arms, legs, neck, and body generally, which had been gradually increasing in severity; no alteration in the urine had been noticed. The mother gave the child senna tea, after which there was free movement of the bowels, but nothing peculiar noticed in the motions; the tongue seemed thick in speaking and swallowing. On seeing the child one formed the idea that it was a case of severe chorea, affecting the body generally, but not the facial muscles. She was unable to walk; heart regular. The elder girl, aged 9, was said also to have had similar movements all over, but not so bad as her sister; she had gradually improved, though I could perceive a slight trace. The brother, aged 11, had eaten some when in school, and became so dull and stupid that he was punished, but the effect soon wore off. The mother some time previously had had a bad cold, for which she was advised by some lay practitioner to grind up a whole nutmeg, and eat it in gruel. She says she felt “very stupid and sleepy, thick feeling in tongue, with slimy sensation”; it was three days before the effect wore off, but she suffered from no twitchings of limbs or body. I placed the child ($4\frac{1}{2}$ years) on 3-minim doses of liq. Fowleri, and when I saw her again, three days later, she was much improved, had walked that day, and the movements generally were much lessened in severity. (*British Medical Journal*, March 3, 1906.)—J. G. B.

Nux Moschata in Stupor.—Dr. George Royal, of Des Moines, Iowa, relates the following case; Female, aged 18, father and mother both neurotic; father takes alcohol in excess; mother has had three attacks of acute mania. Patient had returned one evening from the park, thrown herself upon her bed

with a cry, and the doctor who reached her half an hour later found her unconscious. The mother stated that she had been unusually drowsy all day, and had gone to the park to get some fresh air to see if it would not wake her up. Pupils unresponsive to light; respiration slow, laboured, and stertorous; a sharp cry now and then. She remained in this condition for twenty-four hours, when Dr. Royal was sent for. He found the bladder enormously distended—two pints were withdrawn by catheter—and ascertained the fact that she was menstruating, and that she was always drowsy, although suffering from colic, at that time. *Nux moschata* 30x ended the attack in twenty-four hours, but had to be continued for six months before the drowsy and colicky condition at the menstrual period had disappeared. (*American Physician*, January, 1906.)—T. G. S.

Opium in Bradycardia.—A patient had his pulse reduced to twenty-four beats a minute; it was full and slow; was accompanied with great mental confusion, contracted pupils, flushed face, marked distension of the abdomen, spasmodic contraction of the sphincter ani, frequent urination, and drowsiness. He presented a perfect picture of opium, and on being given this remedy in the 6th dilution was gradually restored to health. (*American Physician*, December, 1905.)—T. G. S.

Psorinum in Furunculosis.—Dr. Beck relates a case of inveterate furunculosis occurring in a lady, and which had troubled her for more than twenty years. The boils were on the anterior aspect of the body, sometimes on the chest, sometimes on the abdomen. They were large, usually isolated, from 2 to 4 cm. in diameter, including the induration of the skin, which formed their base. Their development lasted from four to eight weeks, and sometimes a new set began before the last had fully healed. In order to diminish the painful drawing and twitching in the skin, the patient had gradually come to stoop over forwards, and this, together with the contraction of the cicatrices, had so drawn her together that she could not maintain an erect posture without effort. Sulphur, silica, hepar, arnica, terebinthina, thuja, &c., had all been tried in vain. It was at last discovered that when a child she had been infected with scabies by her nurse, and had been cured of it by the inunction of sulphur ointment. She was given a single dose of 5 centigrams of psorinum 3c. There was no aggravation. The furuncles healed quickly and she had no more, and a report from her three years later showed that they

had not returned. (*American Physician*, November, 1905.)—T. G. S.

Radium Salts. *New Methods of Application.*—Mr. Hugo Leiber, chemist, of New York, has succeeded in dissolving radium salts in such a manner as to form a film or coating on suitable appliances, offering a method of securing *all the rays and emanations* given off by the radium salts without immediate loss of substance, such as would occur if pure radium or aqueous solutions were applied directly. Experiments have been made with mixtures of wood alcohol, acetone, amyl acetate, to which organic acids were added, depending on the character of the material to be filmed or coated with the solvent. The solvent required to be of such a character that the surface of the appliance to be coated was softened, and the radium solution readily imbedded in it. Another quality required of the film was permeability and elasticity. The inventor found celluloid in the shape of rods or plates most suitable; later on, at the suggestion of Dr. Dieffenbach, hard rubber bougies for orificial application were successfully coated. Tests are made with a specially constructed electroscope. The solvent employed is of a solferino red colour, while the radium salts when fixed appear whitish, so that the extent of the coating can be readily discerned from the contrast of colour. The solution of radium salts used for coating are approximately of 10,000 and 25,000 activity, and can be made more powerful if required. Dr. Dieffenbach tried these new radium coatings in a case of inoperable epithelioma of the foot in a man, aged 85. The tumour covered the anterior surface of the malleolus and measured 15 centimetres round and 14 centimetres high. Röntgen rays were being tried. The coated, pointed rods or bougies were introduced into the mass of the tumour at about its centre, protected and kept there two days. The tumour became somewhat umbilicated, and had turned much darker in colour. After another two days new rods were inserted for a like period. By that time the mass was much darker, very friable, and readily detached from an underneath clear, apparently healthy, surface. The case went on to apparent resolution, although at the time of record there were evidences of recrudescence. This case is an example of many others in which similar treatment was adopted. Other methods consist of placing a coating of celluloid in a rubber box about 3 centimetres square and covered with dammarlack. A thin piece of rubber tissue is wrapped about the container and held in place at the site of the lesion by the patient

himself. These are supplemented when required by applying woollen cloths impregnated with radium emanations which are fastened over the lesions to be treated. (*North American Journal of Homœopathy*, December, 1905, p. 796.)—ED.

Radiotherapy in Ichthyosis.—Seeing that the Röntgen rays act in a peculiarly effective manner upon the epithelial elements, and the lesions of ichthyosis being quite superficial, Prof. Ledue, of Nantes, has been treating a child, aged 12, who had been afflicted for upwards of ten years with generalised ichthyosis, which had hitherto defied all treatment. The first *séance* lasted twelve minutes, during which the head, the trunk, and the limbs were successively exposed. At the end of a fortnight marked improvement was visible; there was abundant desquamation of the epidermis and islets of sound skin were visible. A fresh exposure to the rays was made, followed by another fortnight's interval; then a third sitting, and a month later a fourth. Three months after the treatment was commenced the skin had everywhere regained its normal aspect, and the general condition which had previously been very precarious had become absolutely satisfactory. There only remained some involuntary movements of the eyes and slight nervous agitation. (*Semaine Médicale*, September 13, 1905.)—J. G. B.

Salpingitis and Ovaritis. *Treatment.*—Dr. Julia M. Green, in a paper on the treatment of salpingitis, sums up the drugs useful in this complaint in the following six classes:—

(1) The quick, sharp-acting remedies for recent inflammation: Aconite, ambra, antimon. crud., apis, arsenicum, belladonna, bryonia, cantharis, china, chelidonium, cimicifuga, colocynth, lachesis, lycopodium, mercurius, nitric acid, palladium, podophyllum, rhus tox., staphisagria, tarentula.

(2) Those for chronic cases in broken-down constitutions, or for acute attacks based on chronic trouble: Argentum metallicum, arsenicum, asafoetida, aurum, carbo-animalis, cimicifuga, graphites, iodine, lachesis, lycopodium, mercurius, nitric acid, podophyllum, secale, sepia, staphisagria, sulphur, thuja, zincum.

(3) Remedies for gonorrhœal cases: Antim. crud., apis, argent. met., aurum, carbo-animalis, graphites, iodine, lachesis, lycopodium, mercurius, mezereum, nitric acid, secale, sepia, staphisagria, sulphur, thuja.

(4) Those for syphilitic patients: Arsenicum, asafoetida, aurum,

carbo-animalis, lachesis, lycopodium, mercurius, mezereum, nitric acid, staphisagria, sulphur, thuja.

(5) Remedies affecting the right ovary prominently: Aconite, apis, belladonna, chelidonium, iodine, lycopodium, palladium, podophyllum.

(6) Those for the left side: Antim. crud., argentum, cimicifuga, lachesis, mezereum, sepia, sulphur, thuja, zincum.—T. G. S.

Sea-water. Therapeutic Effects of Hypodermic Injections.—Robert Simon was led to try this remedy after reading of the results obtained by Quinton in artificially induced nephritis, and where "retention of chlorides," albuminuria, oliguria, dyspnœa, œdema and exophthalmos rapidly yielded to the *immediate* injection of *isotonic* sea-water. Simon's first patient was a woman, aged 45, alcoholic, who had suffered from Bright's disease for upwards of six years. She had been an inpatient at la Pitié Hospital for six weeks; had been absolutely confined to bed and to a strictly milk diet, with dry cupping occasionally. At the end of the six weeks her condition was stationary. Dyspnœa prevented her sleeping except in the sitting position; there were fine râles in both lungs, puffiness of face and exophthalmos, and œdema of the lower limbs and up to the waist. The quantity of urine varied from 1·8 to 2 litres. Chlorides were 4·4 grams, and albumen 5 grams per litre. Patient's weight was 50·25 kilograms. Hypodermic injections of *isotonic* sea-water were now commenced, 200 cc. being injected every three days. After the second injection improvement was manifest; œdema was diminishing, and pulse and respiration easy. At the third injection the body-weight was found to have fallen to 47·2 kilograms. The improvement proceeded steadily and rapidly, and on the nineteenth day from the commencement of the treatment all signs of œdema had completely disappeared. In twenty-three days the loss of weight amounted to 9·9 kilograms, and nine injections, each of 200 cc., had been administered. "Salt-free" diet was not resorted to, the previous milk diet being simply continued. There was distinct diuresis during the treatment, the quantity of urine several times measuring 3 litres. (*L'Art Medical*, February, 1906, p. 143.)—J. G. B.

Zea Italica in the Treatment of Psoriasis.—Naveau, of Paris, has recently treated three cases of psoriasis, all of considerable standing, and where the usual treatment, both internal and external, had completely failed. The internal remedies used were

either sulphur 6, and arsen., alb. 3x., or merc. sol .6, and arsen. 3x. the remedies being used either on alternate days or alternate weeks. In addition to the above he applied locally to the scaly patches a glycerole consisting of tr. zea italica 2 grams, glycerine 60 grams. This was applied regularly every night, and washed off in the morning with tepid *boiled* water, with the result that all the cases were cured in periods varying from a fortnight to two months, and in no case has there been any reappearance of the eruption. (*Revue Homœop. Française*, February, 1906, p. 63)
—J. G. B.

JOURNAL
OF THE
British Homœopathic Society

No. 3.

JULY, 1906.

VOL. XIV.

All communications and exchanges to be sent to

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A CASE OF PUERPERAL ECLAMPSIA.¹

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MRS. P., aged 34, first consulted me in July, 1904. She had been married for three years, during which time her periods had been regular. Her last period had been ten days overdue, and had lasted for fourteen days. The history seemed to point to an early miscarriage. On examination I found the uterus much retroverted and retroflexed, but easily replaced to the vertical position. There was also prolapse of the left tube and ovary. Under anæsthetic, given on account of the narrow and tender introitus, I replaced the uterus to normal position with the sound, and fitted a suitable ring. This proved to be comfortable and efficient; she gained weight, had better health, and in four months became pregnant. At the third month of pregnancy I deemed it advisable to remove the ring, asking her to see me at the end of the seventh month for the purpose of routine examination to determine the condition of pregnancy and associated state of the important organs and functions. The condition on examination

¹ Presented to the Section of Surgery and Gynæcology, February 1, 1906.

appeared to be normal, the head was lying in the pelvis, and foetal heart sounds could be heard. Incidentally she mentioned that her feet and legs had been swelling, and I found that this was more than is usual at this state of pregnancy, there being slight œdema below the knees. Examination of the urine revealed the presence of albumen, the quantity on boiling with nitric acid and allowing to stand being one-sixth. Rest, a milk diet and merc. cor. 3x were ordered. During the next month the œdema increased very rapidly and extended to the thighs, abdomen, and rest of the body, so much so that she experienced great difficulty in getting into bed, her feet being "like logs." The amount of albumen in the urine had increased to two-thirds. She had now reached the end of the eighth month, and in view of the serious condition of the albuminuria and general œdema, I deemed the time had come for averting a catastrophe. My first step was to avail myself of the advice of my colleague, Dr. Burford, who saw the patient on the morning of August 9, and concurred with me that an immediate and rapid inducement of labour was the only course open in the interests of mother and offspring. At 10.30 a.m., under an anæsthetic, I dilated the cervix with the fingers sufficiently to allow of the introduction into the lower segment of the uterus of three gauze sponges. These were left inside for twenty-four hours without inducing any labour pains beyond a backache. They were then removed, and the membranes ruptured. The os was now about 2 inches in diameter, the edges soft and thinned out, while the foetal head could be felt presenting. The labour pains came on at once and increased in number and severity. The patient began to be drowsy and slept between the quickly-recurring pains. It may be noted here that the urine for some days had been becoming scanty, and during the previous twenty-four hours was only one ounce in quantity. At 7 p.m., I called and found labour proceeding satisfactorily, the head engaged in the cervix, which was dilating normally. At 12 midnight, I was hurriedly called to find the patient passing into the comatose stage of an eclamptic fit. Half an hour before, the nurse had noticed the patient fixing her gaze on the ceiling. When spoken to about it, she moved her eyes for a few moments in the usual manner, but they became fixed again. Then her head became twisted to one side, and a very violent seizure ensued, lasting about ten minutes. Gradually the tonic and clonic contractions passed off, and the calm of unconsciousness supervened. In this state I found her. Knowing the capabilities and nerve of the nurse, I at once administered chloro-

form and proceeded to delivery by forceps. Though the head was high up, there was no difficulty in adjusting these. The head was quickly pulled down to the perineum, which proved tight and resisting. A lateral incision with scissors into the right side of the vulva soon overcame this difficulty and permitted a rapid delivery. However, to my surprise, the uterus, which had been noted to be unusually full, probably with increased amniotic fluid, did not subside in the usual way, and on examination there was discovered another foetus with head presenting within the cervix. This was in turn seized with the forceps and soon delivered. The placenta came away easily, the lateral perineal incision was sewn up and the vagina flushed with perchloride of mercury douche (1—3,000). From the first onset of the fit, which lasted half an hour, to the final toilet of the vagina and perineum, including the time for the extra stringent antiseptic precautions, one hour had elapsed. The patient slept on for two hours and woke quite conscious. Convalescence was normal and uneventful. No more fits occurred, the oedema rapidly subsided, so that by the third day she had become quite thin, urine had been passed freely, and the albumen had reduced to a trace. I then left for my holiday, leaving the patient in the hands of Dr. Horace Saunders, to whom I am indebted for guiding the case through the remainder of the puerperium to a satisfactory conclusion. On the eighth day the albumen increased a little, due, it was thought, to a too generous and albuminous diet. On return to milky food, the albumen diminished. Diet is now more generous, but there is still a faint trace of albumen. Mother and children did well. The latter, being a month premature, were kept snug with cotton-wool and hot bottles. The photograph which I now pass round, taken a few days ago, is sufficient evidence of the health of the trio.

REMARKS.

Statistics.—Such, you will admit, was a more satisfactory result than seemed probable early in the progress of the case. Statistics show that with intra-partum eclampsia, of which the foregoing was a case, the maternal mortality is about 25 per cent., with a like mortality for the foetus. Ante-partum eclampsia shows a maternal mortality of about 45 per cent., and foetal mortality of 69 per cent. Unless prompt action had been taken when the clinical signs increased in severity, this case might have been one of ante-partum eclampsia, with its almost doubled risk to the mother and trebled risk to the children.

THE CAUSE OF ECLAMPSIA.

But before dealing with the question of procedure in such cases let me say a word or two about the cause of eclampsia. Here pathologists and clinicians are still groping in the dark, but the more recent and reliable observations would point to toxic material in the blood as the probable cause. The origin of the toxic elements are various. Some (Schmorl) ascribe them to the placenta, where certain ferments are supposed to originate and gain access to the maternal circulation. Others, again (Fleisher and Bouchard), look on the toxæmic condition as allied to uræmia, where extractive materials, present in the urine, become retained in abnormal amount in the body and produce the convulsions. Among the latest observations may be mentioned those of Ludwig and Savor, who believe that as a result of certain metabolic processes, dependent on the deranged metabolism in pregnancy, ferments are liberated, producing an auto-intoxication. The action of the ferment is expressed by the symptoms of eclampsia. Its removal takes place by the urine after the convulsion. The origin of the ferment, whether in liver, urine or elsewhere, is not determined.

WARNING SYMPTOMS.

The main point of paramount clinical value, which we may cull from each of these various theories, stands out clearly and is itself our guiding idea on which to take action; it is, "Suspect any interference with the permeability of the ureal filter."

Hence albumen in the urine of a pregnant woman must be looked upon as a grave omen. Most of us know this, but how few examine the urine of their pregnant patients with that regularity which duty calls for. Some hold that the diminution in the amount of urea is the most serious sign, and certainly in the case just narrated, the passing of one ounce of urine in twenty-four hours was quickly followed by the eclamptic seizure.

PREVENTIVE TREATMENT.

Time will not permit me to refer to many other interesting and all-important problems relating to eclampsia, so I

shall pass to a few sentences relative to treatment. Here, as in everything, prevention is better than cure, and is the keynote of treatment in this dire condition. Taking the toxæmic origin as our working hypothesis we must limit as far as possible the tendency to produce urea and other nitrogenous metabolic by-products.

The precautionary measures to be observed are summed up very succinctly by Jewett, of New York, in his practice of obstetrics, and may be set down here.

(1) Reduce the amount of nitrogenous food to a minimum.

(2) Limit the production and absorption of toxic materials in the intestine and tissues of the body, and assist in their elimination by improving the action of the bowels, the kidneys, liver, skin and lungs.

(3) If necessary, remove the source of the foetal metabolism and of peripheral irritation in the uterus by the emptying of that organ.

TREATMENT.

This last clause indicates also the curative line of treatment, and is exemplified in my case, when, on the rapid increase of albuminuria and œdema and on the like diminution of urea, immediate steps were taken to empty the uterus.

In conclusion, a few practical points may be of value:—

(1) Operative intervention must be preceded and accompanied with most rigorous antisepsis and asepsis. The added danger of manipulation and possible sepsis have been urged against interference or in favour of delay. But the obstetrician who knows his methods and is, from experience, confident in their precision, need fear no bogey.

(2) Full anæsthesia, to allow of full and rapid dilatation, with little damage to the cervix, is essential to rapid operation and the subsequent welfare of the patient.

THERAPEUTIC MEASURES.

(3) As regards therapeutic measures, my experience is confined to this case. Influenced no doubt by a pathological symptom, when albuminuria was first discovered, I chose

mercurius corrosivus, strength 3x, as the medicine. That was continued up to confinement, and, with the exception of a few intercurrent remedies, up to this present date. Though the happy issue cannot with certainty be claimed for the medication, still the fact remains that under its administration good resulted.

The therapeutic question in all its varied aspects I will therefore leave to colleagues who I know are well fitted to discourse to us with profit from their wider experience in that condition, so dreaded by the obstetrician, puerperal eclampsia.

The PRESIDENT said that more than once during this session it had been his pleasure to congratulate the reader of a paper on the success of his methods, as he did on the present occasion. No one could have been in practice for many years without seeing many phases of this dreaded disorder. They used to be told that it was almost unknown in organic diseases of the kidneys, but he had seen a fatal case which occurred in a patient, the subject of psoas abscess and amyloid disease. He had generally used ordinary bougies for the purpose of inducing labour, but he had no doubt that the gauze recommended by the author was quite as good. He had seen a case of convulsions in the second or third month of pregnancy. One was, perhaps, very apt to defer bringing on premature labour. He was not sure that it was right to induce it in all cases. He could call to mind one case in which, providentially, premature labour came on spontaneously at about the sixth or seventh month and turned out very well, but the patient suffered from albuminuria a long time. He took her to see Sir William Roberts, and after a general prognosis Sir William said, "If the patient gets well in two years you will do well." A good deal of trouble had to be gone through, but in about two years the albuminuria ceased, and it only returned on one occasion after some years, and the patient continues well.

Dr. MADDEN said that he had never seen a case of puerperal eclampsia, but a case in which there had been a marvellous escape from the disorder had just passed through his hands. A young married lady of 23 or 24 years of age had engaged him to attend her in her first confinement, which was due in December. He examined her urine in the middle of October and found it perfectly normal. About December 20 she sent to him to say that she was

suffering from swelling and pain in the legs and feet. He immediately sent for a specimen of her urine again, but did not get it for two days, and upon examining it he found a large proportion of albumen, more than one-half of a column. He consulted Dr. Burford, and Dr. Burford and he both thought that it would be well to get her at all hazards into a private hospital, but almost immediately afterwards he (Dr. Madden) was summoned, and reached her house, five miles from his own, at about eleven o'clock at night. He found the lady perfectly well, and labour going on satisfactorily, the head being engaged in the pelvis. She had intense œdema; the legs were hard and swollen, and the swelling extended to the whole of the thigh and a little way up the back; but she had no symptoms referable to the brain or eyesight. From the time that he entered the house until about three o'clock in the morning he gave her chloroform, when the labour came off. She had a quiet night, and he stayed till breakfast time. Before he left he gave apis. In the evening he found the patient going on well. Urine began to pass rapidly, and she passed 50 or 60 ounces a day for the next three days, and the œdema cleared away with equal rapidity. About thirty hours after labour the neck and cheeks were swollen, and the swelling went down to the shoulders, and she felt as if she was being choked; but this condition went down very rapidly and she made an uninterrupted recovery. The albumen was reduced to about one-twelfth within a week, and there was still a trace, but neither she nor her child seemed to have suffered in the slightest from what was threatened. The treatment which Dr. Johnstone had mentioned was, of course, such as they would all adopt in a similar case.

Mr. WYNNE THOMAS related a case in which he had a lucky escape similar to that of Dr. Madden. About six years ago the wife of a gardener came to him at about the end of the sixth month of her first pregnancy, and said that she was suffering from very severe headaches, and that for the last week she could hardly keep anything down. He found that her urine was very scanty, and loaded with albumen. He took her to the hospital and consulted Dr. Burford as to whether they should bring on labour, and Dr. Burford recommended that they should wait twenty-four hours. At the twentieth hour the labour came on of itself, and she had a perfectly easy time. The child weighed 3 lbs., and is still living. The woman had had two children since, but there had been no recurrence of the former symptoms. In another case he was attending a lady a month before the time

she expected to be confined, and the urine had a specific gravity of 1010. She was passing altogether about 15 or 20 ounces, and he estimated the urea at about 200 grains per diem. The patient was put on milk diet. He estimated the urea every day, but in no case did it ever exceed 250 grains a day. The specific gravity went down to 1006 and never went above 1011. The labour was perfectly natural. Since then she had had another child, and the urine remained perfectly normal.

Dr. MILLER NEATBY wished to ask whether any of the members present were prepared to definitely state that evacuation of the uterus was after all the right treatment of eclampsia. In a paper which appeared not long ago in the *British Medical Journal*, Dr. Herman said in effect that emptying the uterus was of no use, and that though many people seemed to think it was imperative to do something, he (Dr. Herman) believed that it was much better to pursue a policy of "masterly inactivity."

Dr. FRANK A. WATKINS asked Dr. Johnstone for information with regard to the statement that patients suffering from this disease had been subject to physiological albuminuria during early life. Another point was whether it was a fact that the thyroid in these cases did not undergo the amount of hypertrophy which is normal to pregnancy. It had been said that eclampsia was due to the omission of this development, which upset the balance of the renal blood tension; it having recently been shown that the general blood tension is maintained by the antagonistic effects of the secretion from the thyroid and supra-renal capsule. A French writer had drawn attention to the fact that in nearly all cases of eclampsia the examination of the urine had been omitted. This is a very important point, for the inference is that if albuminuria is detected early in pregnancy, that the consequent measures adopted are usually effectual in preventing the precipitation of an attack of eclampsia. It was not meant that the presence of albumen in itself was a sure sign that eclampsia would follow, but it was one of the most important signs connected with the disorder. With regard to treatment, Dr. Carter, of Manchester, recorded some time ago two very remarkable cases of recovery from uræmic convulsions by the inhalation of oxygen, and he (Dr. Watkins) thought a similar puerperal eclampsia would be well worthy of trial.

Dr. E. A. NEATBY said that Dr. Johnstone's paper was a model of conciseness and brevity. Eclampsia was a very interesting study, especially in the etiological field. One of the causes which had been adduced was a so-called biological, not a chemical

cause. He alluded to the deportation of villi which took place, to some extent normally, in pregnancy, causing some other forms of blood poisoning than those which had been mentioned or else acting as an embolus. A case occurring in the early stage of pregnancy, interesting in this connection, had been mentioned by Dr. Hawkes. Another suggestion as to the cause was the lessened alkalinity of the blood, and on this account salines had been given with success both by the bowel and intravenously. With regard to the emptying of the uterus, in the first case which he had early in his practice, he did not perform that operation, and the patient died. In the second case he emptied the uterus, and the patient got better; but he did not think that one could judge properly by single cases of that kind. The recent practice at the Rotunda, where they had a large number of confinements every year, was to allow the uterus to empty itself. They treated with large doses of opium, giving half a grain of morphine straight away, and administering as much as two grains a day, at the same time giving eliminative treatment; and it was said that the maternal mortality was now reduced from 45 to 16 per cent. In the report from which he was quoting they did not distinguish between ante-partum and post-partum cases. No one had referred to bleeding. It was very curious how the absence of knowledge in the old school was indicated by the most heroic and most opposite forms of treatment. If practitioners had a knowledge of drug action and of the rule of similars, they would be able to treat this condition very much better, even though they had not ascertained the actual pathology of the disease. Possibly drugs might do a great deal, especially in the preventive stage. With regard to the remarks of a previous speaker, he (Dr. Neatby) knew that thyroïdin had been used with some success in the treatment of cases of eclampsia.

Dr. GOLDSBROUGH said that he had attended five or six hundred cases of childbirth, but had not had a case of eclampsia. He had had one case of albuminuria, whom he attended with the late Mr. Harris. Premature labour was induced in this case at about seven months and three weeks, and the patient made a good recovery from the albuminuria, but the retina was permanently damaged. The case was looked upon as a very serious one at the time, but there was no sign of convulsion. He had read of many cases in which the emptying of the uterus had failed to cause a cessation of the convulsions. The effect of that operation might thus be a disputed point, though the weight of the evidence was decidedly in favour of evacuating the uterus. He should like to

ask Dr. Johnstone whether he knew if his patient suffered from loss of sight.

Dr. JOHNSTONE, in reply, said that there had been no complaint on the part of his patient as to defective vision. The loss of vision in Dr. Goldsbrough's case might be looked upon as a result of the conditions associated with albuminuria, just as eclampsia was usually associated with the same. He thought that as the maternal circulation had to bear the strain of the circulation in a uterus at full term and the nourishment of the foetus, it might be argued *a priori* that the sooner that strain was relieved by inducement of labour the better. Moreover, as the usual outcome of eclampsia, probably Nature's way of cure, was onset of labour, it were better to assist Nature than allow her to struggle unaided. He was therefore inclined to early interference.

The main point to be learned from the case and to be remembered in future cases, fortunately rare, was that early recognition of albuminuria by routine examination of the urine in the later months of pregnancy was a decided help in the management of the cases and might lead to the prevention of calamity. He always insisted on a careful physical examination (abdominal as well as pelvic) in the seventh or eighth month of pregnancy, together with analysis of the urine. This gave the accoucheur increased confidence as to how to treat the case when the time arrived.

ON THE OPERATIVE TREATMENT OF UTERINE DISPLACEMENTS, WITH SPECIAL REFERENCE TO HYSTEROPEXY AND ITS AFTER-RESULTS.¹

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A FEW months ago, a well-known German writer prefaced an important paper on the subject before us to-night, with the remark that it required some courage to bring it before his readers on the ground that so much had already been written.

¹ Presented to the Section of Surgery and Gynæcology, February, 1, 1906.

If such a modest attitude is justified by the prolific writings of German gynæcologists, the same does not hold good in this country.

Until the last few months very little except isolated reports have appeared, and before this Society the subject has, I believe, never been ventilated.

That the treatment of uterine displacements is not yet a *chose jugée* is shown by many facts, and by none more strongly than by the divergence of view as to the nature of the disorder. When I was in Stockholm, Professor Salin informed me that, in his clinique, retroflexions were regarded as normal. If a patient had pelvic symptoms and a mobile retroflexion without notable prolapse she was told there was nothing the matter with her womb. As to his results in such cases I cannot say. That he is not alone in his views is shown by opinions in America and Germany. Dr. Lucy Waite,¹ of Chicago, examined 1,000 women, and found retroflexions in 390; of these 15 per cent. had no gynæcological symptoms, and 24 per cent. were complicated by tumours, pyo-salpinx, chronic disease of the ovaries and myo-metritis. According to this observer "A normal uterus may lie in any position without causing symptoms, and when they occur they are due to other causes."

Similar views are expressed by Graefe,² who, however, allows that it is permissible "in cases of sterility to attempt a cure by remedying the displacement."

On the other hand another German writer (Menge) avows that all cases of retroflexion are pathological. With these differences of judgment as to the nature of the cases it is not surprising that there are divergencies of practice in their treatment.

Before a sister Society³ I have suggested a classification of cases of displacement, indicating those in which success may be attained by (1) medicinal treatment alone (with a selection of the remedies used); (2) by medicine aided by

¹ *Jnl. Amer. Med. Assn.*, 1905, and *Brit. Gyn. Jnl.*, May, 1905.

² *Samml. sur Abhandl.*, Bd. v., Heft 2. *Brit. Gyn. Jnl.*, May, 1904.

³ Western Counties Therapeutical Society, reported in *Monthly Homœopathic Review*, November, 1903.

exercises ; (3) by pessaries, and finally those in which operative measures are needed to assure a cure.

That there are many cases curable by drugs I have no doubt, but of the patients presenting themselves for hospital treatment, the number so curable is relatively small.

While the aid of the pessary is undoubted, it is at best only a makeshift. Klein,¹ of Munich, reports 37 per cent. of "doubtful results" where the uterus remains in the forward position only so long as it is supported by the pessary, falling back as soon as it is removed. I have under my observation at the present time two patients, one an American lady of leisure, and the other a housekeeper in a large establishment, in whom this happens. In each of these cases I have repeatedly kept the uterus forward for a considerable period together, six to nine months, only to find after a few weeks that the symptoms had returned and the uterus had resumed the backward position.

The last named writer records 52 per cent. of cases where the uterus falls back even with the pessary *in situ*. This occurs in varying percentage with us all ; and in some cases although the pessary retains the uterus in position, the patient's sufferings may persist.

With these facts before us, it is evident that there are a considerable number of cases in which non-operative measures fail to bring the desired relief.

The endeavour of this paper will be to show whether or not operation can claim successes denied to non-surgical treatment, and if so, what is the best form ?

What are the chief operations which demand our attention ? Four will be alluded to in passing. That of shortening the round ligaments is too well known to require any lengthened description or comment. It was introduced by our countryman (Alexander of Liverpool) about the year 1880, at a time when it was less safe to open the abdominal cavity than has been the case for ten years or more.

It has met with varying success at the hands of different operators. Its first recommendation is that it is an extra-

¹ *Münchener Med. Woch.*, 1904, p. 1412.

peritoneal proceeding, and its main advantage is that it is a suspension and not a fixation. Its weak point is that when the original cause of the displacement is still acting, the ligament, which has already stretched before operation, will continue to do so after, and a relapse is not unlikely to occur. It is also occasionally a difficult operation; the round ligament is not always discoverable, even when the inguinal canal is freely opened, and when found it will not always "run" or pull freely out of the abdomen; sometimes the ligament breaks off while being pulled upon. Shortening of the round ligaments is still practised by individual operators and by its worthy introducer.

In the 1901 *Reports of the Royal Southern Hospital, Liverpool*, he expresses his confidence in the method after an experience of twenty-one years. Many "chronic sufferers from old retroflexions, who have failed to obtain relief from pessary or other methods," have been cured by him, but in these cases "it is essential that the uterus should be straightened before the operation, and kept in position till healing is complete." He recommends for this purpose a "galvanic stem supported on a Hodge." Although Alexander states that the breaking off of the ligament is quite exceptional, he records two cases in his own practice occurring in one day; in one patient both ligaments "broke off hopelessly on the slightest tension," in the other the right ligament "snapped off just as he was about to stitch it."

Le Roy Brown (*New York Medical Record*, February 22, 1902), reports 230 Alexander operations, with two deaths "not attributable to the operation." He states, as does Alexander, that the uterus must be free from adhesions, but Alexander has lately used his operation for adherent cases after opening the peritoneum by posterior colpotomy, and separating adhesions. It is said to have no effect upon pregnancy.

This operation can hardly be said to have become general, and indeed is less often performed now than some years ago. This is due to the increased frequency and greater safety of abdominal sections.

It is perhaps natural that a small personal experience should have more influence on one's judgment and practice.

than have the reports of a more extended experience of other operators.

Some twelve or thirteen years ago, I performed this operation in a few cases. On each occasion the round ligaments were more difficult to find than I expected. In one case one of them broke off, and in another one of them refused to be drawn out. It is not therefore surprising that in both these cases a relapse took place, and one of the patients submitted afterwards to hysteropexy, with the best possible results. I have not performed this operation for several years, and feel that I am unlikely to do so again.

The enhanced safety of cœliotomy has led to a not unimportant modification of Alexander's operation—that of *shortening the round ligament intra-peritoneally*. I have not done this or seen it done. The reports I have read vary in this particular—in some the ligaments, after being folded are stitched to the abdominal wall one inch or more away from the uterus, while in others (*e.g.*, Menge's 130 cases¹) they are stitched to the parietes at the point where they leave the uterus. All Menge's cases he reports as successful, but they should be reckoned as hysteropexies rather than as Alexander cases.

The next method requiring notice is *shortening of the utero-sacral ligaments*. The importance of these supports was brought prominently to notice in this country by the translation of Schultze's book on displacements; by him these ligaments are called the ligaments of Douglas or the musculus retractor uteri. They are folds of peritoneum running from the sides of the uterus at the level of the isthmus and extending outwards, backwards and upwards to the outer margins of the second sacral vertebra. These folds are strengthened by fibrous and muscular tissue, and form the upper lateral limits of the pouch of Douglas. When intact they keep the uterus in the forward position and prevent its prolapsing. When they undergo contraction after pelvic inflammation the junction of the body and cervix is drawn upwards and backwards, marked antelexion occurs,

¹ *Brit. Gyn. Jnl.*, August, 1904, p. 36.

and the mobility of the uterus is notably lessened. When, on the contrary, they are stretched, prolapse quickly ensues, and retrodeviation becomes possible. It is to overcome this stretching that shortening of the utero-sacral ligaments was devised. It may be carried out by the vaginal or the abdominal route. Johnstone, in the *American Journal of Obstetrics*, July, 1905, reports two cases treated in this way reached through a posterior colpotomy. Both were successful. That this is a rational method of treatment can hardly be doubted, but it is liable to the same disadvantage as is the shortening of the round ligaments, viz., that after the operation further stretching may occur. Should any cellulitis follow it, however, the opposite condition (viz., contraction) may ensue, with pronounced antelexion and fixation of the uterus.

Perhaps the most recent procedure for very aggravated cases is that devised and carried out by Christopher Martin of Birmingham, described by him in a recent paper at the British Gynæcological Society. It consists in extirpating uterus and vagina, and stitching up in such a way as to bring together the edges of the pelvic fascia so as to make a firm fibrous diaphragm, extending from one side of the pelvis to the other, and having adherent to it the bladder in front, and the rectum behind. In principle, it resembles an operation for radical cure of hernia. With respect to this, I have only to say that it must be borne in mind that nature has not designed the layers of fascia to meet in a central raphe, and a good deal of dissection is necessary to bring their edges into view and into apposition, and considerable tension exists during union. Such a severe operation requires for its justification a great amount of previous danger or distress, and a very radical and permanent success as its result. With exemplary candour, Mr. Martin admits that in all his four recorded cases, "the convalescence . . . was complicated with deep-seated suppuration." The ultimate result was good, but it is too soon to say how long it will last.

The only other method I propose to mention before passing on to the main subject of this communication, is vaginal fixation. This excellent operation is one of very limited

applicability, being of no use in cases complicated by prolapse. It was first performed without opening the peritoneal cavity, with the result that the sutures not seldom found their way into the bladder. Subsequently the peritoneum was opened after pushing back the bladder, as in the early stages of vaginal hysterectomy. For suitable cases its results are good, but I do not propose to enter into the subject at the present time.

For the purposes of this paper I use the term hysteropexy as a generic one in its broadest etymological sense—fastening of the uterus. By ventral hysteropexy is meant stitching of the uterus to the abdominal wall.

The idea is no new one. The earliest record I have come across is its performance by an Italian surgeon, on the dead subject, in the early sixties of last century. In the year 1869 Koeberlé stitched the stump after an oöphorectomy to the abdominal wall. This is the first recorded case of hysteropexy in the living subject.¹

This was followed by Heywood Smith's operation referred to in a recent discussion at the Obstetrical Society. I have not been able to discover the reference to this case, but Dr. Heywood Smith was good enough to tell me that it was in the 'seventies, and certainly before the introduction of Alexander's operation. It did not assume any prominence, however, until taken up in a modified form by Olshausen of Berlin, in the year 1886. The technique of his original operation is entitled to a first place in the descriptions to be given here.

According to Hofmeier, one of his pupils, who wrote upon "ventrifixation for uterine displacements" in the fiftieth volume of the *Zeitschrift für Geburtshülfe und Gynäkologie*—a number dedicated to Olshausen in celebration of his seventieth birthday—it consisted in stitching the round ligaments to the abdominal wall. The needle was inserted close to the uterine origin of the ligament, the suture passing deeply through the muscular layer of the parietes and surrounding the ligament. The sutures were

¹ Russell Andrews on "Ventral Fixation of the Uterus."—*Jnl. of Obst. and Gyn.*, B. E., August, 1905.

tied and cut short after being passed on both sides. His great point at this stage was that no uterine tissue should be included in the loop of the ligature. He stated that the Fallopian tube, if no longer in active service, might be included in the ligature. As time went on, some slight modification of this procedure took place, the chief point being that some of the muscular tissue of the uterus was taken up by the stitches. This appears to be his present practice.¹

Toward the end of the same year, Howard Kelly read a paper detailing his method, which had been carried out in the previous year. This differs essentially from Olshausen's in that the sutures are expressly passed through uterine tissue. Kelly's early practice represents one of the varieties still carried out—namely, that of suturing the anterior surface of the uterus to the parietes. Of this he subsequently writes: "I rejected" this "over six years ago on account of the mechanical disadvantage in which it left the uterus to resist subsequent retro-displacement; for a uterus lifted in this way hangs with its whole weight upon its attachments, and the permanent correction of the displacement must depend upon the strength of the adhesions binding it to the anterior abdominal wall." At this stage—about the year 1892—he adopted the method of passing the sutures through the posterior surface of the fundus and body. This brings the uterus into a state of somewhat exaggerated anteversion or even ante flexion. The downward pressure of the viscera tends only to increase this, and to stretch the adhesions formed, without encouraging retroflexion.

Richardson, of Newcastle, in the *Lancet*, of December 23 last, publishes a "new method" of ventral hysteropexy, after which he has had good results in thirteen cases. In two of them labour had followed without any departure from a healthy standard, and the uterus had remained in good position. In two other cases pregnancy was far advanced.

The operation consists in a suspension of the uterus by the divided round ligaments. Briefly described, the steps

¹ *Loc. cit.*, p. 384.

are as follows:—After opening the abdomen the round ligaments are tied and divided near their points of entrance into the inguinal canals. The distal ends of the proximal portion are seized in pressure forceps, and the uterus is pulled up into the abdomen as high as it will comfortably go. At this level the distal ends are drawn through openings made (subcutaneously) in the musculo-aponeurotic structures of parietes about $1\frac{1}{2}$ in. from the cut edge. After the peritoneum and rectal sheath are stitched up, the ends of the round ligaments are sutured to the aponeurosis transversely, the ends being made to meet, and being sewn together in some cases. The advantages claimed for this method are that it is permanent, that no “bands” are formed, that no interference with pregnancy and labour ensue, and—by no means least in importance—that it does away with the need for vaginal plastic operation in cases of procidentia.

As far as ten cases can prove anything, I think his claims are substantiated by his results. For cases of procidentia I intend to try this method.

Maunsell's method of ventro-suspension, as described at the British Gynæcological Society, July 13, 1905, consists in bringing the fundus uteri forwards into the incision with a vulsellum, which is first drawn forwards and downwards. The upper part of the peritoneal opening is closed again with fine silk, as far as the protruding fundus, which then stands out through a transverse peritoneal slit. The edges of this opening are then united to uterus—in front $\frac{1}{2}$ in. from the fundus, and behind $\frac{3}{4}$ in. from that point. The fundus is thus rendered extra-peritoneal; it sinks down into a depression, such as we used to see in the old days of extra-peritoneal treatment of the pedicle in hysterectomies. The sides of this depression should be brought together to prevent the formation of a “dead space” in which fluids could accumulate. The advantages claimed are: (a) support with mobility, (b) no interference with bladder or (c) pregnancy, (d) no formation of bands, as after direct central fixation. The last claim is a theoretical one.

Many minor differences of method are introduced by various operators. They consist in such points as the

number of sutures used, their situation with reference to the fundus, &c. One surgeon (Pozzi) uses a continuous suture in place of the usual interrupted ones ; another stitches the whole of the anterior surface of the uterus to the parietes, thus obliterating the space into which bowel might possibly slip and become strangulated. Some operators make the incision laterally, so as to stitch the uterus to the uninjured central peritoneum. In this way the adhesion is less dense than when it is stitched to the wounded surface. But these are hardly differences of principle. The two great and important varieties are (1) where the uterus (or even the adjacent round ligaments) are stitched to the deep and unyielding structures of the parietes, muscle and fascia, and (2) where the sutures penetrate only the peritoneum.

The former is, strictly speaking, a fixation ; the latter may be better described as a suspension. The former involves a permanent departure from the physiological condition of mobility of the organ, and it is the same whether the anterior or posterior surface be sutured. Schultze compares the uterus to a pendulum, and remarks that it is hardly fair to speak of its having "a" position. It should rather be described as having a range of positions. In the degree in which this form of hysteropexy is a success, it proportionately curtails or abolishes this range of movement. Whether or not its abolition is in practice a disadvantage of any moment, will be presently considered.

A variety of classifications might be suggested for these cases, but the purposes of this paper will best be met by one based on treatment.

Four varieties may be named :—(1) Simple non-adherent retroflexions. (2) Adherent retroflexions. (3) Retroflexions with diseases of the appendages. (4) Prolapse of uterus and vagina with or without retroflexion.

The indications for operation are those dictated by common sense. *Firstly*, the patient must have *sufficient suffering and disability* for the exercise of daily duties and the enjoyment of daily pleasures to warrant the contemplation of surgical aid. *In the next place*, the medical adviser and the operator must be satisfied that the *sufferings are due*

to the pelvic lesion. Finally, minor measures, after a fair trial, must have proved fruitless, or at any rate, partial and palliative only.

Concerning the first condition, as we are yet without a "pain gauge," something depends upon the patient's own estimate of her sufferings. Still more depends upon her position in life. A woman who is dependent upon her own exertions for a livelihood will insist more urgently on a speedy, complete, and permanent method of treatment than one with means and leisure. We must further judge of the advisability of operation by the effect on the patient's physical condition—her state of nutrition, her walking and lifting powers, her heart's action, her ability to undertake the duties of social or married life, and her sleeping powers.

As to the second condition, it is not always easy to decide whether or not the symptoms are due to the displacement. If rest considerably relieves them, and especially if replacement of the uterus and its maintenance by tampons brings temporary freedom from pain, there are grounds for concluding that the sufferings are due to the local lesion. Where neurasthenia forms a complicating element in the case, it is much more difficult to judge of the importance of the pelvic condition. Even where the general state is obviously the first in order, both of time and rank, it is highly probable that a small peripheral ailment may act as an irritant to an already weak and hyper-sensitive condition. Where neurasthenia and a simple retroflexion co-exist the greatest care is needed not to over-estimate the importance of the displacement, and not to give too high an estimate to the patient of the value of operation. A little later, when considering my own cases, I hope to be able to refer to one or two bearing on this point.

The third condition—the exhaustion of all minor measures—may be accepted as *de rigueur* in all cases of the first class. I may be open to criticism here, but I would give a more prolonged and thorough trial of such means to a woman of 40 to 50 years of age than to one much younger. In the young woman her life lies before her, to be made or marred by her ability or inability to adjust herself to her environ-

ment. To my thinking, it is a pity and a sin to allow a young woman to drift into chronic invalidism simply in deference to a sentimental objection to operating upon her reproductive organs, especially where there is no question of "mutilation." The moral effect of an operation, with a cure immediately beyond it, is much less depressing than is a permanent invalidism, with the sexual sphere as its centre and focus.

In cases of the second and third class the prolongation of a course of treatment which the result may show to have been only "tinkering," is less called for. It should be possible to estimate with some degree of accuracy what are the probabilities of success by rest, medicines, pessaries, &c., in a case complicated by pelvic adhesions. If the causative inflammatory attack is still in the near past, if there is evidence of recent exudation or of existing elevation of local temperature, then it is the inflammatory condition, rather than the displacement it has induced, which demands treatment. But given a case with a history of past pelvic inflammation, followed by pain, with a fixed uterus or with adnexal swellings, there can be no object in delaying operative measures.

In the fourth class the only word I have to say is that in cases of prolapse, far more than in retroflexions, it is the actual displacement which calls for treatment. When once the failure of mechanical aids has been demonstrated, the advisability of operation cannot be questioned. It does not even arise until medicinal therapeutics have been exhausted. Though both uterus and vaginal walls prolapse, it is mainly the vaginal descent which causes the distress. This is to be met by the usual plastic measures, varied according to the needs of each case, and carried out at the same sitting as the hysteropexy, if the patient's strength will permit.

The most important part of the subject lies still before us, viz., the consideration of the disadvantages and after-results of the operation. Before passing on to this I propose to introduce here such facts as my own cases enable me to advance, and those gathered from the articles I have read. I may record my indebtedness to that published by Andrews

of the London Hospital,¹ by far the most informing of any single article I have come across. It is to be regretted that incompleteness of detail tends to vitiate the conclusions of all observers, or, at least, to render them less accurate and certain. No case can be regarded as properly reported where *it is not* clearly stated whether the uterus is stitched to the peritoneum and subserous tissue only, or whether aponeurotic and muscular elements are also included. In all my own cases the former will be here described as suspensions, and the latter as fixations. It is a little difficult not to use the latter term generically, as is so often done, but it will not be so used intentionally. By preference I use the cumbrous term hysteropexy.

My own operation may be described as a direct central suspension. In detail it is as follows: The abdomen is opened in the median line by an incision large enough to admit the hand. The uterus, appendages and pouch of Douglas are examined; the first named is brought to the surface, and a silkworm-gut suture is passed deeply into its substance immediately—say $\frac{1}{8}$ inch—posterior to the points of entry of the Fallopian tubes. This suture is utilised in place of a vulsellum for pulling upon the uterus, which is brought into a position of anteversion thereby. A half circle needle is next taken and threaded with No. 2 Chinese twist silk, the point is inserted from within outwards into the left parietal peritoneal flap, $\frac{1}{4}$ inch from the cut edge. It passes into the subserous tissue, but *not* into the aponeurosis, emerges again on the inner surface $\frac{1}{2}$ inch further away from the middle line, and is then made to enter the uterus about $\frac{1}{4}$ inch below the previous suture on the posterior surface. The suture is next passed through the right peritoneal flap, entering $\frac{3}{4}$ inch and emerging $\frac{1}{4}$ inch from the margin. Two, three or four sutures are thus inserted according to the weight of the uterus and the density of pre-existing adhesions.

The fundus is usually found about 1 inch above the pubes. The parts are now sponged, and it is ascertained that no intestine occupies the utero-vesical pouch. The

¹ *Loc. cit.*

silkworm suture is now threaded again, and each end passed through the whole thickness of the abdominal wall. The fine silk threads are tied and the peritoneal wound is closed with No. 1 silk, thus entirely excluding the uterus and its sutures from the abdominal incision. The sheath of the rectus is then closed by a continuous re-sterilised chromic catgut suture, and finally the skin edges are adjusted with silk or with metal clips. The silkworm-gut suture is then tied; it is removed about the tenth or twelfth day.

I have been able to collect fifty-eight of my own cases, the majority with sufficiently recent news of their condition to enable one to judge as to the after-results of the treatment. These, of course, I shall not read to-night, but hope that the Editor of the Journal may see fit to publish them in tabular form in due course. Of these, fifty-one were done more than a year ago. The remaining seven, done within the last twelve months, are introduced to give an idea of the condition a few months after operation. My first, No. 1 in the table, was done in 1897, after the failure of an Alexander already referred to. Until the year 1903 I saw and heard of this patient more or less regularly. The physical finding was always good, and she was able to do the arduous work of a nursemaid. She was a single girl aged 24, and had borne a child many years before, she is counted as married in this list. She was unable to continue earning her living before the operation. She was the youngest patient, and the eldest was a woman aged 64, with bad proclivitas. The ages of the patients run as follows:—

24 to 30 years	...	...	...	14	}	44
31 „ 40 „	...	...	...	30		
41 „ 45 „	...	...	...	9		
46 „ 65 „	...	...	...	6		—
						59

This gives a total of one too many, because on one patient the operation was twice performed. A woman of 40, with a pelvic lesion sufficient to warrant hysteropexy,

is practically past the child-bearing age. One of my cases done in 1899, at the age of 38, miscarried in the middle of 1900, sixteen months after the operation—when $39\frac{1}{2}$ or 40 years old. This patient (No. 4) has had five children, the last fifteen months before the operation.

Of the series, forty-three patients were during the child-bearing age, but twelve were single or widowed, and three had had double oöphorectomy, leaving twenty-eight presumably likely to have children.

Referring to the classification already suggested, we find thirty-five cases of simple retro-deviations, seventeen with adhesions, three of which were complicated by prolapse; twenty-eight had prolapse without adhesions.

My impression is that a larger proportion than the notes state were adherent cases, but I cannot now prove this belief.

Thirty of the patients had abnormalities of the appendages, either cystic or inflammatory, sufficiently pronounced to be commented upon in the notes, and in many instances this condition was serious enough to warrant removal. In eight the left ovary was removed; in three the right; and in four both. It may be remarked here that while the operation of ventro-suspension in simple retroflexion is one of the easiest, safest, and quickest for which coeliotomy is performed, it is far otherwise when the uterus is bound down by dense and broad adhesions, and the appendages are embedded in organised inflammatory products. The separation and removal of these are often extremely tedious, and the shock of operation is proportionate to the extent and density of the adhesions. I must confess to some surprises in the matter of uterine and adnexal adhesions when the abdomen has been opened. This is especially the case with light adhesions which are not enough to immobilise the structures or to form any bulky mass. They may, nevertheless, be enough to prevent recovery without operation. In no case have I failed to bring the uterus forward, but in one (No. 16), the backward pull of the scar-like intrapelvic tissue caused a failure to ensue and the uterus to reassume its flexed position. Pelvic inflammation and its results bring the

gravest difficulties in this operation—indeed, in many of the cases the displacement and the hysteropexy are but incidents in a serious case of salpingo-oöphoro-peritonitis.

The general health suffers in proportion to the severity of the inflammation, and the degree of original sepsis acting as a cause. Constant pain, dysmenia, menorrhagia, dyspareunia, dyschezia, loss of flesh, of appetite, and of domestic happiness, form items of varying prominence.

Leaving aside these intra-pelvic complications, prolapse of the vagina and uterus form another large class of cases in which ventral fixation or suspension is called for. The patients have considerable local discomfort, and not seldom their ability to work is diminished, but their bodily health is not so seriously impaired as in those first dealt with. From the point of view of the surgeon, they are chiefly noteworthy because they necessitate a more prolonged operation or chain of operations, involving not seldom two sittings. In cases where the uterus is heavy, the endometrium unhealthy, and the cervix lacerated and hyperplastic—as so often happens—a preliminary curetting and trachelorrhaphy may be needed. If the symptoms are not urgent it may be permissible to see if this procedure and the rest enjoined thereby are enough to cure the case. If there be much prolapse at the same time—and prior to the hysteropexy—repair of the pelvic floor should be undertaken. It is this condition of prolapse and procidentia which forms a chief hindrance to a full and permanent cure. There is not a very uncommon class of cases, which goes by the name of “relaxation of the pelvic floor” or outlet, which are difficult to account for and to cure. They are supposed by some writers to be due to a congenital defect. In single women, and sometimes even in young girls, without any known cause, an absolute procidentia occurs. The laxity of the parts is such, that there appears to be no tone or contractile power present, the uterus lies outside the vulvar orifice, and the immensely redundant vaginal walls form a huge mass as large perhaps as two fists. The walls are thick, when returned they lie in heavy folds in the pelvis, and appear to be truly hypertrophied, pulling down the uterus by their weight. The rima

pudendi is so dilated that a hand may be as readily inserted as at the close of parturition. These are the cases which tax the ingenuity of the surgeon, and which have led to so heroic a measure as that advocated by Mr. Christopher Martin, and described earlier on. One of my own cases, a cook (No. 19), was a single woman, aged 55 years. Her procidentia was so bad as to oblige her to give up her work. As far as I could learn she was a virgin, and certainly had not borne children. In her case a very extensive anterior and posterior colporrhaphy and narrowing of the vulvar orifice, in addition to ventro-fixation, resulted in great improvement. But I cannot honestly call it a cure, for some three years after she came back with a threatening of return of prolapse of the vagina, and was given a ring pessary. I have not seen her very lately, but her reply to my enquiry shows that *she* at least is not dissatisfied. She says: "Before the operation I was quite unable to walk without much discomfort, and could not continue my daily work. Less than six months after operation I was working as much as ever."

In another case which struck me very much at the time, I experienced a still greater failure. The patient was a young girl sent to me by Mr. Frank Shaw, and operated on by the same method, at the Buchanan Hospital, St. Leonards. I have seen other cases in young subjects since, but none more surprising to me. As I forget this girl's name, I have not been able to look up her notes or include her in this list. All I can say is, that I believe within a year Mr. Frank Shaw told me she had again been obliged to resort to mechanical support. The gain in both these cases seemed to be limited to their becoming able to retain a useful pessary, which before was impossible. I cannot help thinking there is an essential difference between this condition and that of a procidentia due to the traumatism of a large family. For these cases, Lefort devised the operation of forming a median longitudinal raphé uniting the anterior and posterior vaginal walls, thus making a double vagina. Richardson (already quoted) believes that his suspensory operation enables the vaginal walls to regain their tone, and avoids vaginal narrowing. In my opinion it might do so in

these last-named traumatic cases, but not in the aforesaid "relaxed pelvic floor" of congenital or trophic origin.

Prolapse and procidentia are not frequently associated with adhesions. Any considerable degree of adhesion would prevent the prolapse. But three of my cases had retro-deviation, prolapsus and adhesions associated. Eight patients had a complete procidentia, some with deep ulceration of the vaginal wall or uterine cervix. Twenty-three others had well-marked prolapse, mostly with retroflexion. For none of these would vaginal fixation have been of any use. I shall allude to the permanency of these combination cases under another heading.

Next in order let me consider as a group those in which single women were operated upon. I place these arbitrarily in one group, because on examining them together, their results seem less satisfactory than any other grouping I could have made, and that consequently there may be a lesson to be learnt from them viewed together, which would be overlooked if they were regarded merely as isolated units.

There are nine cases of single women who had not borne children. Of these, one (No. 19) has been described as one of relaxed pelvic floor and does not require further consideration. No. 7 is that of a young woman operated upon in 1899, aged 31. She had sacral pain, dysmenorrhœa, pyknuria, with dysuria, and retroflexion. Soon after the operation she went abroad, and I lost sight of her until this year, when I heard from her, and she reported herself as in no way benefited by the operation. For three years a stitch was working out, and she had pain and discharge connected with this. When the stitch came away the wound healed at once, but the last two months she has had almost unendurable menstrual pain "of a different kind." "While sneezing something seemed to give way, and this acute pain came on." She says, however, she is able to get about and do her work.

No. 10 was operated on in 1900, at the age of 34, for left iliac pain and bearing down, associated with retroflexion and prolapse of left ovary. She was always better

if she could wear a Hodge pessary, but that was not possible for long together on account of pressure on the ovary. I have seen her on and off since, and in December last found the uterus in good position. She reports that all the symptoms for which the operation was done have disappeared. But she is still pale, thin, ill-nourished and melancholy—profoundly neurasthenic. This condition is but little bettered, though I believe she gets through a great deal of heavy domestic work.

No. 11 was done in 1900; this patient was also 34 years of age. She had bearing down and dysmenorrhœa, associated with retroflexion and prolapse of both ovaries. For several years after operation the bearing down continued, but has not been experienced for the last twelve months. The dysmenia is cured. She reports herself as weak; she has gained "relief but not a complete cure."

Case 16 is worth a fuller report. She was 28 years of age, single. She was admitted suffering from dysmenia with profuse menstruation. Uterus was retroflexed. In June, 1901, I performed ventro-suspension, after breaking down adhesions and removing the right ovary. Patient made a good recovery. I saw her in January, 1902, and found the uterus again retroflexed, with a return of dysmenia and menorrhagia. There was also pyknuria and dysuria, with pain in abdomen. In February of that year I reopened the abdomen and stitched the posterior surface of uterus to the abdominal wall (peritoneum). There was no trace of band or adhesion connecting the uterus and the parietes. The left ovary was found to contain a large hæmatoma, probably a lutein cyst, and to be embedded in adhesions; it was accordingly removed. Recovery was slightly retarded by a stitch abscess. In January, 1906, patient wrote in answer to inquiry, "I have benefited by the operation, have kept fairly well this last year, only had one reminder of my old trouble, and then I think I caught cold. Periods have quite stopped, not been on for nine months."

This patient was a poor miserable subject, but in spite of her relapse and second operation being necessitated, she

made a better final cure than some of the others in this group.

No. 27, aged 35, operated on in 1903 for pyknuria, dysuria, bearing down and sacral pain and dysmenia, associated with retroflexion. In December of last year I saw this patient and found the uterus forward and sharply anteflexed. She was very much better as regards the symptoms just named, but complained of slight returning sacral pain and of a vast assemblage of distant neurotic symptoms. She remained thoroughly ill-nourished.

No. 31, aged 29, operated on in 1903 for sacral and right iliac pain with retroflexion and vaginal prolapse, has sent no recent report. This case was complicated by two small myomata for which myomectomy was carried out. The immediate result was good.

No. 50, aged 26, was conjointly under my care and that of Mr. Knox Shaw, who removed the appendix vermiformis for a persistent pain in the right side. While in the hospital she was found to have menorrhagia and a retroflexion, for which, at the same sitting, I performed ventro-suspension in June last year. I saw her a few days ago, and found the uterus forward and moveable, but there was no improvement in menstruation. She is less constipated than before operation. This patient also is pale, thin and tall.

No. 56, a patient of Dr. Vincent Green's, aged 32, was operated on in January, 1904, for dysmenia, retroflexion, abdominal pain and general inability for mental or bodily exertion. When last seen the uterus was in good position. Appendicectomy and suspension were done at the same sitting, and a good immediate recovery took place. Dr. Green reports, "I attended her within six months of her operation for a slight return of the symptoms, but since then she has been well. I saw her last week, and she expressed herself as being quite well, and she certainly looked it."

The consideration of this group of cases will increase my cautiousness in operating on neurasthenic patients, or at any rate in the promises I make as to the part of their

sufferings likely to be removed by the operation. It seems to me that all these require, in addition, a prolonged course of treatment for their neurasthenia. I say in addition, for it is probable that without it the results would soon be undone by the persisting peripheral irritation. The more meagre the physical indications, the less likely is the operation to be a success, and this is especially so in neurotic single women.

No. 44, a neurasthenic patient, aged 38, married, the mother of one child, suffering with pyknuria, sacral pain, bearing down, retroversion, vaginal prolapse, prolapse of both ovaries (one cystic). In spite of a troublesome stitch abscess, she reports herself as having benefited by the operation, and able to do her work "fairly well." Her medical attendant, Dr. Clifton Harris, volunteered the statement that "her general condition, which was neurasthenic, has greatly improved." Apart from the stitch abscess he says, "the operation has been entirely successful." This patient, though neurasthenic, was not one of the thin, anæmic, ill-nourished type.

A few words now as to the immediate general results of my cases. Of the fifty-eight reported, convalescence was complicated in two, by thrombosis of the saphena vein, the stiffness from which, in one, lasted some years. In this (No. 5) there were no adhesions and the case was quite simple and quick. In the other (No. 43) the patient had procidentia. Anterior and posterior colporrhaphy and a myomectomy were performed at the same time, but the results of the thrombosis were speedily got over. In the first of these two cases "fixation" was stated to have been performed, and in the second suspension.

In two cases there were stitch abscesses before leaving the hospital, and in one a hæmatoma of the incision. One patient (No. 57) had pneumonia during convalescence at Eastbourne. I did not see her and do not remember the cause of it. One patient, who had a pyosalpinx which ruptured during removal, developed a pelvic abscess which burrowed into the thigh and required opening like a psoas abscess. This prolonged her stay in the hospital some

weeks. In this case of course the hysteropexy was a mere incident. The patient left the hospital weak, but quite recovered from the operation, and reported herself recently as having very much benefited; she is able to walk well, is in general good health, has had no return of pain, and has gained flesh.

All the rest of the cases made a good recovery at the time. I am happy to say I have had no fatality in a hysteropexy, whether done for simple displacement or conjoined adnexal disease. In eight cases the operation was accompanied by both anterior colporrhaphy and perineorrhaphy; in five by colporrhaphy only; in three by appendectomy; in thirteen by removal of one ovary, and in four of both; in nine by curetting (mostly associated with some other vaginal operations); in ten by repair of the cervix; in two by myomectomy; and in one by operation for hæmorrhoids. It will be seen, therefore, that many of these were tedious cases. They were not always done at the same sitting. Thirty-six were found to be completely successful after a length of time varying from nine years to six months. Of fifteen I have no report sufficiently recent to enable me to say anything definite as to remote results; in six I regard them as poor, even though the uterus remains in good position; and in one the patient, whom I have not seen, says she has received no benefit.

As regards permanency of cure of the displacement, in one instance the uterus relapsed; in another a certain degree of retroversion had taken place, but I think this was due to the sutures being placed in the fundus and not in the posterior surface. In the rest, as far as I know, the uterus remained in good position. The chief failure as to permanency refers to the vaginal walls, to which reference has been made.

I may here hazard the opinion that in a number of cases where the uterus is found to be in good position, but mobile, no adhesion took place, or only a temporary one. This and the stitches may have acted long enough to allow a return of the uterus and its supports to a normal condition. I have only reopened the abdomen in one instance, and no bands

were then found.¹ Other operators have found bands of greater or less length and density suspending the uterus. Having dwelt at some length on the unsatisfactory cases, I may be allowed to narrate some instances as types of the more gratifying majority.

No. 42, aged 64, complained of bearing down and sacral pain. On examination there was found to be complete procidentia. The vaginal wall was also hypertrophied, redundant, and ulcerated. In September, 1904, I performed a posterior surface suspension, and at the same sitting anterior colporrhaphy, perineorrhaphy and trachelorrhaphy. This patient, though an elderly woman, made an excellent recovery. In January, 1906, she wrote, "have better health than have had for many years."

No. 15, married, aged 27, suffered from bearing down and lumbar pain, dyspareunia, and dysmenia. Period was irregular and profuse, and uterus was retroflexed. In June, 1901, I did a posterior surface suspension, and at the same time curetted and repaired the cervix. Both ovaries were found to be prolapsed. Patient made a good recovery. In August, 1903, I saw her, and found the uterus forward and high up, no dyspareunia. In January, 1906, she wrote, in answer to my enquiry, "The operation has made a woman of me, for which I am very thankful. I never was so well before. I only feel a little pain when I get cold, and at my periods. I am not always regular, sometimes three weeks, sometimes six, but that does not seem to hurt me."

I have presented some facts as regards permanency drawn from my own patients. This is a point on which little stress has been laid by previous writers. It may be that my numbers are too small to enable others to form an opinion—such as they are, I leave them for my hearers' consideration. My own impression regarding this point is sufficiently clear from the narrative. Perhaps the immediate sequel will suggest that in some instances the results in other hands were a little too permanent! I have earlier on stated that of my series twenty-eight married women were

¹ Since writing the above I have had to re-open in a second case, and found a long cord-like band, about the size of a No. 4 or 5 silk ligature.

at a child-bearing age, and only four pregnancies ensued. One ended in abortion, the next in a natural labour with twins, a third in a natural labour, and the fourth has attained the fourth month without any unusual pain or trouble.

As regards the effects on pregnancy, the best list is compiled by Andrews,¹ and I shall append a table from his article. He concludes, *inter alia*, that abortion is not more common after hysteropexy than under other circumstances, citing thirty-six cases in 395 pregnancies; out of the same pregnancies twenty-one were forceps cases.

It would require a long paper to itself to go into detail as to the distortions of the uterus occurring after hysteropexy. Where the fundus is really fixed, the cervix is frequently drawn so high up as to be out of reach of fingers or forceps. In some instances it is a canal several inches in length. The os may be situated anywhere from the sacral promontory to the first lumbar vertebra. Where the cervix is extremely high, the fundus or anterior surface lies over the pelvic inlet. In many recorded instances the anterior wall remains undeveloped, the chief growth taking place in the fundus and posterior surface, creating a corresponding distortion. In some instances the uterus is fixed at one corner, and an oblique distortion follows. That malpositions of the foetus result is not surprising. Ten transverse presentations, for example, took place in 189 cases—about ten times the usual proportion. Post-partum hæmorrhage does not seem to have occurred in many cases (8 out of 395). It is not easy to judge of the number of patients who suffered from exceptional pain during pregnancy, on account of its being so seldom mentioned, either way. It is believed that undue fixity of the uterus must and does cause pain by dragging on the adhesions to the scar. Another grave sequel is rupture of the uterus, which seems to have been traceable in three instances to the operation. The malpositions and distortions already mentioned furnish the gravest indictment against hysteropexy, for they have been so serious as to lead to twenty cases of Cæsarean section. These are set forth by

¹ *Loc. cit.*

Andrews, and still more recently by Seegert, assistant in the Universitäts-Frauen Klinik in Berlin. From the last-named I quote. He collected an account of the disturbances recorded by forty authors. Of most startling note are twenty-two cases of Cæsarean section, due, not to pelvic deformity, tumours, &c., but to distortions produced by ventro-fixation. In nineteen of these, either the report or the known custom of the operator, or the finding at the time of the Cæsarean section, proves the uterus to have been thoroughly and really fixed to the parietes. The pull on the scar during a uterine contraction could in one instance be plainly seen. In the remaining three the attachment of the uterus is called a suspension, but in two of them an ovariectomy and a myomectomy had complicated the suspension.

In some instances, unfortunately, the life of both mother and child were sacrificed.

Of the rest of the cases collected by Seegert the following is a brief summary : laparotomy during labour for separation of adhesions, with delivery by forceps (one case), and after ovariectomy, one ; rupture of uterus, one ; slow labour and post-partum hæmorrhage, one ; forceps, seven ; turning, 14 ; abortion, 11 ; craniotomy for twins, 1. Of all these in only three was the operation of suspension performed, and the disturbances caused were excessive pains (forceps), slow labour with post-partum hæmorrhage, and slow labour requiring forceps. No further argument is needed to prove that any operation or complication of the same, which induces undue fixity of the uterus to the abdominal wall, is liable to cause serious difficulty during delivery, and it is consequently unjustifiable intentionally to bring about such a fixation. In the result it is the same whether the fixity is brought about by the persistence of unabsorbable ligatures—stout silk or fishing gut—inserted into the fibrous and muscular layers of the parietes ; by extensive adhesions produced by scarification, by too extensive stitching, or by the inflammation accompanying myomectomies and oöphorectomies ; or (more commonly) by some degree of septic inflammation producing a deep, dense, unyielding scar.

The bad results following suspension are few and are comparatively slight. (The cases of Cæsarean section following suspension are already explained.)

With respect to strangulation by a band extending from uterus to parietes, much has been written and spoken of its dangers. Only four cases have been put on record, by Jacobs, Olshausen, Dardanelli and Sonnenfeld.

Olshausen's case was not performed by his method. Two of these patients had the anterior uterine wall fixed to the parietes—a proceeding which, as Kelly has pointed out, offers greatest facility for the abdominal pressure to force the uterus downwards, so tending to the formation of a band.

In a third the "ileus" was produced by kinking, due to adhesions which were not freed at the time of operation. One may say, therefore, that the danger of ileus, though real in theory, is not a very serious one in practice, provided a proper technique be followed.

There are now for comment some remaining disadvantages and dangers attributed by various speakers and writers to this operation. They are: (1) pulmonary embolism—a possibility after any major operation, not more prominent here than elsewhere; (2) peritonitis, sepsis, stitch abscess; these may be classed together, for probably the peritonitis and the stitch abscess are due to a mild local infection from imperfectly sterilised ligatures and sutures—a vanishing danger as our methods improve. Of general sepsis I know nothing in these cases, and presume, if it happened, it would be from some damage to the intestinal walls during the separation of adhesions, or infection from the rupture of a pyosalpinx, &c. Nevertheless, the chance of such complication seems to me less than in any other laparotomies when the cases are "simple." (3) Hernia is less likely to occur, because the fundus is in itself a protection. In only one of my hysteropexy cases have I found a hernia of the scar recorded, but I think in the early years, before the introduction of the three-layer suturing, others must have occurred which have escaped record; (4) pain through fixity of the uterus, noticed during coughing, sneezing, or other straining

efforts, is not infrequent in the early months after operation ; similarly I have met with (5) pyknuria, due to the same cause and of temporary duration ; (6) parametritis would be explained by the remarks already made on sepsis. I have seen it only in the case of pyosalpinx recorded.

Attempts have been made to indicate the length of time necessary to pursue mechanical treatment before operation. Each case must be treated on its own merits. I fancy the tendency is to persevere too long with such methods, until the condition is aggravated, sepsis induced, and the patient weakened. Moreover, it is within the experience of us all that patients get careless and sometimes forget the existence of the pessary, which may be found to have penetrated the bladder, and require to be literally dug out of its burying place in the vaginal and vesical walls. I may say, as regards the majority of my own cases, they had had a wearisome period of previous treatment, owing to the pressure on my hospital beds.

Very briefly let me summarise : Many cases of displacement require operative relief where other methods have failed, or are inappropriate. In the great majority of them hysteropexy is the most suitable operation. The variety always to be selected during active sexual life is direct suspension ; where prolapse or procidentia co-exist, extensive vaginal plastic operation must be carried out, or perhaps Richardson's operation. The danger of dystocia is largely due to fixative instead of suspensory methods ; where relapse occurs, it is usually in the vaginal and not the uterine element where failure takes place. Neurasthenic cases, especially in single women, should be undertaken with reluctance and caution.

SYMPTOMS BEFORE OPERATION.

No.	Year and Reg. No.	M. or S.	Age.	Bladder.	"Bear- ing down."	Pain.	Menstruation.
16	490, 1901	S.	28	.. ..	..	.. .. ..	Dysmenia. Reg. +
16A	192, 1902	S.	29	Frequency and dysuria.	..	Abdominal	+ . Dysmenia
17	539, 1901	M.	42	.. ..	Yes	Rectal	Reg. -
18	649, 1901	M.	39	Frequency and dysuria	Yes	Abd., right side of	Reg.
19	681, 1901	S.	55	Frequency and dysuria	Yes	Sacral and left side of abd. Unable to walk	.. .. .
20	718, 1901	M.	39	.. ..	Yes	Sacral	Reg. -
21	748, 1901	M.	37	Dysuria	Yes	Sacral	Irreg. +
22	989, 1901	M.	29	.. ..	..	Sacral	Dysmenia. Reg. +
23	195, 1902	M.	37	Frequency and dysuria	Yes	Abdominal	Dysmenia. Reg. -
24	705, 1902	M.	44	.. ..	Yes	.. .. .	Reg. +
25	706, 1902	M.	33	.. ..	Yes	Abdominal	.. .. .
26	175, 1903	M.	27	.. ..	..	Dyspareunia. Drag- ging left side	Dysmenia. -
27	188, 1903	S.	35	Frequency and dysuria	Yes	Sacral	Dysmenia. Reg. -

UTERUS.

Backward displacements.	Prolapse.	Procidentia.	Appendages.	Children.	Date of last child.	
Retroflexed	.. ..	.. ..	.. .. .	.. ..	.. ..	1871
Retroflexed	.. ..	.. ..	Left ovary cystic	.. ..	.. ..	1871
Retroflexed	.. ..	.. ..	Hæmorrhoids. Eczema round anus	Five	16 years previously	1871
Retroflexed	.. ..	.. ..	Lac. cervix and perineum	Two	9 years previously	1871
Retroverted	Yes	No	Ovaries prolapsed. Vagina so small would not admit pessary	.. ..	.. ..	1871
Retroverted	Yes	.. ..	Right ovary prolapsed. Cystocele	Ten	4 years previously	1871
Retroverted	.. ..	.. ..	Lac. cervix	Two	3 years previously	1871
Retroflexed	Yes	.. ..	.. .. .	Three	2 years previously	1871
Retroflexed	Yes	.. ..	Ovaries prolapsed. Left ovary cystic. Lac. cervix and perineum	One	8 years previously	1871
Retroflexed	Yes	.. ..	Right ovary cystic. ? tubercle of tube	Eleven	4 years previously	1871
Retroflexed	Yes	.. ..	Right ovary large and cystic	.. ..	.. ..	1871
Retroflexed	.. ..	.. ..	Left ovary cystic	One abortion.	6 years previously	1871
Retroflexed	.. ..	No	.. .. .	.. ..	.. ..	1871

OPERATION.				PROGRESS.	
Date.	Nature.	Adhesions.	Additional operations.	Immediate.	
June, 1901	Ventro-suspension	Yes	Right oöphorectomy	Good	Jan., 1902 troflexed dysmen- Sept., 1902 lar. M
Feb., 1902	Posterior surface suspension	Yes	Left oöphorectomy	Stitch abscess, pelvic abscess	
June, 1901	Ventro-fixation	.. ..	.. .. .	Good +
July, 1901	Posterior surface suspension	Yes	Curetting. Emmett. Double oöphorectomy	Good.	-
Aug., 1901	Anterior surface suspension	.. ..	.. .. .	Good	1902 rej ben +
Aug., 1901	Posterior surface and suspension	Yes	.. .. .	Cystitis.	.
Aug., 1901	Posterior surface and suspension	.. ..	Amputation of cervix. Perineorrhaphy. Trachelorrhaphy. Curetting	Good	.. ..
Nov., 1901	Ventro-fixation	.. ..	.. .. .	Small stitch abscess +
Feb., 1902	Posterior surface suspension	.. ..	Left oöphorectomy	Good	Jan., 1902 forwar +
Oct., 1902	Posterior surface suspension	.. ..	Double oöphorectomy	Good	July, 1902 Ut
Oct., 1902	Posterior surface suspension	.. ..	Left ovary incised. Right oöphorectomy	Good.	
Feb., 1903	.. .. .	Yes	Left ovariectomy. Right oöphorectomy	Good	May, 1903 quantiti + displace
Feb., 1903	Posterior surface suspension	.. ..	.. .. .	Good	Dec., 1903 well up. Slight r Many n ill-nouri

Remote.	Subsequent pregnancies.	Patients' own reports.
2. Uterus again re- currence of a and menorrhagia. 14. Period irregu- lar better	.. .. .	Jan., 1906. "Yes, have benefited by opera- tion. I have kept fairly well this last year, only had one reminder of the old trouble, and then I think I caught cold. Periods have quite stopped; not been on for nine months." Jan., 1906. "Have benefited very much indeed by the operation; my general health is con- siderably better than before, for which I am very grateful."
Report. "Immense benefit received"	.. .. .	Jan., 1906. "Before the operation I was quite unable to walk without much discomfort, and could not continue my daily work. Less than six months after operation I was working as much as ever, and am still able to do a fair amount."
.. .. .	.. .. .	Jan., 1906. "Have greatly benefited by the operation. The only thing I suffer from is tiredness after outdoor exercise. I am truly thankful I went under the operation."
.. .. .	(Twins.) One, normal, 1903	Jan., 1906. "I have to take care, and not get over tired, as it is then I feel a return of the dragging pain and throbbing in my left side, otherwise I enjoy very good health."
106. Uterus quite 1. No prolapse	.. .. .	Jan., 1906. "I have greatly benefited by the operation. The only time I feel pain now is when I cough; now and again there is a sudden pull at my side where the old pain used to be, otherwise I am quite well, and feel as I did when a young girl."
104. Quite well. uterus forward	.. .. .	Jan., 1906. "Nothing whatever to complain of. A most complete cure. No discharge or unpleasant results of any kind."
1. No Dysmenia, increased. No menstruation Uterus forward, Sharp ante flexion. returning backache. medical symptoms. shed.	None	Jan., 1906. "I can work, and have benefited in every way."

SYMPTOMS BEFORE OPERATION.

No.	Year and Reg. No.	M. or S.	Age.	Bladder.	"Bear- ing down."	Pain.	Menstruation.
43	919, 1904	M.	44	No	Yes	.. .. .	.. .. .
44	987, 1904	M.	38	Frequency	Yes	Sacral	Reg. -
45	211, 1904	M.	35	.. ..	Yes	Sacral	Dysmenia. Irreg. +
46	830, 1904	M.	33	Frequency	Yes	.. .. .	Dysmenia. Reg. -
47	M. H., 1903	M.	27	Frequency	Yes	Hips. Spine	Dysmenia. Irreg. +
48	E. P., 1905	M.	33	.. ..	..	.. .. .	Dysmenia
49	L. S., 1905	M.	47	.. ..	Yes	Abd.	.. .. .
50	K. A., 1905	S.	26	.. ..	..	Abd., right side	Dysmenia. +
51	520, 1905	M.	52	.. ..	Yes	.. .. .	.. .. .
52	437, 1905	M.	35	.. ..	..	Dyspareunia. Sacral	Dysmenia. Irreg. +
53	455, 1904	M.	30	.. ..	..	.. .. .	Dysmenia. Reg. +
54	943, 1905	M.	37	Frequency	Yes	Sacral	Irreg. +
55	R. G., 1895	M.	39	.. ..	Yes	Sacral. Pelvic	Dysmenia. +
56	E. A., 1904	S.	32	.. ..	..	.. .. .	.. .. .
57	K., 1904	M.	39	.. ..	..	Sacral. Right iliac	Dysmenia. Irreg. +
58	G. C., 1905	M.	36	.. ..	Yes	Sacral. Right iliac	Dysmenia

UTERUS.

Backward dis- placements.	Prolapse.	Procidentia.	Appendages.	Children.	Date of last child.	
.. ..	Yes	Yes	Right ovary prolapsed. Lacer- ated perineum	Ten	10 years previously	1874
Retroverted	Yes	.. ..	Both ovaries prolapsed. Left ovary cystic	One	17 years previously	1874
Retroflexed	.. ..	.. ..	Lacerated cervix, ovaries pro- lapsed, movable kidneys, bi- lateral	Two	6 years previously	1874
Retroflexed	Yes	.. ..	Lacerated perineum	Two	4 years previously	1874
Retroflexed	Yes, vag.	.. ..	Left ovary prolapsed	One	2½ years previously	1874
Retroverted	.. ..	.. ..	.. .. .	.. ..	.. ..	1874
Retroflexed	.. ..	.. ..	.. .. .	Three	13 years previously	1874
Retroflexed	.. ..	.. ..	.. .. .	.. ..	.. ..	1874
Retroflexed	Yes	Yes	Ovary cystic	One	28 years previously	1874
Retroflexed	.. ..	.. ..	Left ovary large, prolapsed	Two	11 years previously	1874
Retroflexed	.. ..	.. ..	Left ovary and tube prolapsed	.. ..	.. ..	1874
Retroflexed	Yes. Vag.	.. ..	Lac. cervix	Three	7 years previously	1874
Retroflexed	Yes	.. ..	Lac. cervix	One	9 months previously	1874
Retroflexed	Yes	.. ..	.. .. .	.. ..	.. ..	1874
Retroflexed	.. ..	.. ..	Both ovaries prolapsed	.. ..	.. ..	1874
Retroflexed	.. ..	.. ..	Left ovary cystic	.. ..	.. ..	1874

OPERATION.				PROGRESS.	
Date.	Nature.	Adhesions.	Additional operations.	Immediate.	
Nov., 1904	Posterior surface suspension	.. ..	Anterior and posterior colporrhaphy. Perineorrhaphy. Myomectomy	Phlebitis, left leg	Jan., 1905 an
Dec., 1904	Posterior surface suspension	.. ..	Left oöphorectomy	Good	Jan., 1906
Feb., 1905	Posterior surface suspension	.. ..	Curetting. Trachelorrhaphy	Good	Jan., 1906 and mo
Sept., 1905	Ventro-fixation	.. ..	Colporrhaphy. Perineorrhaphy	Good	Jan., 1906 No pr sound down."
Feb., 1903	Posterior surface suspension	.. ..	.. .. .	Good.	
June, 1905	Posterior surface suspension	Yes	Curetting	Good	5 months good.
Sept., 1905	Ventro-suspension	.. ..	.. .. .	Good	.. ..
June, 1905	Posterior surface suspension	.. ..	Appendicectomy	Good	Jan., 1906 forward prolapse
June, 1905	Ventral suspension	.. ..	Colporrhaphy, perineorrhaphy	Good	.. ..
May, 1905	Posterior surface suspension	Yes	Removal of ovarian fibroma. Left oöphorectomy	Small hæmatoma at upper part of incision	.. ..
May, 1904	Anterior ventral fixation	Yes	Curetting. Left oöphorectomy	Good	Jan., 1906 position
Nov., 1905	Ventro-suspension	.. ..	Emmett	Good	Jan., 1906 position prolapse
1895	Posterior surface suspension	.. ..	Double oöphorectomy	Good	Re
Jan., 1904	Ventro-fixation	.. ..	Appendicectomy	Good	April, 1906
July, 1904	Fundus suspension	Yes	.. .. .	Pneumonia	Jan., 1906 retrover better. No proli
.. ..	Posterior surface suspension	Yes	Left ovary incised	Good	

Remote.	Subsequent pregnancies.	Patients' own reports.
06. Can get about d do her work.		
3. Uterus is in good position	.. ..	Jan., 1906. Note from patient's medical attendant. "Her general condition, which was neurasthenic, has greatly improved. Uterus in good position. There has been a stitch sinus at upper part of wound, which has been scraped and sewn up. With that exception, the operation had been entirely successful."
06. Uterus forward able. No prolapse.		
6. Uterus forward. olapse. Perineum . No "Bearing		
after, walking power No displacement	Jan., 1906. Three months pregnant.	
.. ..	.. ..	Jan., 1906. "I am feeling so much better."
3. Dysmenia. Uterus and movable. No	.. ..	O. P. notes 'R.' 104.
.. ..	.. ..	Jan., 1906. "I am better in health than I have been for the last three years."
.. ..	.. ..	Jan., 1906. "Have benefited most decidedly by the operation, but still feel rather weak, tiring very quickly. The only trouble I have is constant backache."
6. Uterus in good Anæmic.		
5. Uterus in normal No tenderness or		
6. Cervix smaller. mained well.		
04. Uterus in good position.		
06. Uterus slightly ted. Very much Dysmenia better. apse.		

THE USE OF LIGHT ENERGY IN THERAPEUTICS.¹

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FROM the central orb of our system there radiate into space countless streams of force, a few of which, falling upon our earth and its atmospheric envelope, and coming into contact with the atoms of matter therein contained, cause them to vibrate in such a way as to bring about the various manifestations of energy which, according to the effect produced upon our senses, are called sound, heat, light, electricity and chemical action.

At some time or another each one of these forms of force have been utilised for the purposes of healing the various ills to which flesh is heir, and to none of them does greater interest attach than to light itself, which has been used from time immemorial by man for the cure of disease. The Persians worshipped the sun; the Brahmans, Buddhists and Hindus all knew the value of its beneficial action in states of ill-health, and the Jews were instructed in the mystic pages of the Kabbala that "light is the primordial essence of the universe, that all life and motion proceed from it, and that it is the vital dynamic force of Nature." The same book also declared that it is by the study of light that we are enabled to acquire a knowledge of the unknowable or causal world, and that light is Jacob's ladder by which we ascend to celestial knowledge. To some this would appear to be but playing with words; I would, however, beg such to consider that there exists in light the force which, by its gentle and beneficent influence, can kindle the spark of life in the dormant seed, and in its fierce and penetrating power can extinguish not only micro-organic life, but may deal death even to man himself. Such, then, is the nature of the force which we are about to consider.

¹ Presented to the Section of General Medicine and Pathology, March 1, 1906.

The modern scientific application of this all-powerful force dates from about the middle of the nineteenth century, when two Americans, Dr. S. Pancoast and General Pleasanton began using blue and red light for the treatment of diseases. I believe I am right in saying that both these gentlemen were Theosophists, and doubtless the source of their knowledge was the translations of Eastern books on occultism, which are teeming with instructions on the use of the finer forces of Nature for the purposes of training the mind and keeping the body in health. It is worthy of remark that much of the philosophy of the great Sir Isaac Newton is to be found in this ancient literature, and Pancoast suggests that Newton had been exploring these mines of occult lore, and had arrived at his great discoveries by following up clues gained therefrom.

Dr. Babbitt, of New York, considerably extended the work of Pancoast and Pleasanton, and bringing to bear upon his subject a greater play of the imagination and a more concentrated mental application, he naturally gained a far clearer insight into the basic principles of light and colour, as well as into the constitution of matter generally, and his book on the subject contains in almost every page suggestive passages and many useful hints on treatment. We may, moreover, find in it the germ, and indeed more than the germ, of much of the work carried out by Finsen in later years.

The stimulus given by the researches of the latter observer, and his great success in the treatment of lupus by concentrated sunlight, led to a more general recognition of the value of light energy for medical purposes.

I cannot close this brief historical sketch without giving honourable mention to one of the modern pioneers in the realm of light therapeutics. I refer to Dr. Margaret Cleaves, of New York, whose work is in every sense worthy of emulation, and I should like here to acknowledge my great indebtedness to her writings for much of the material presented to you to-night.

In the opening paragraph I emphasised the fact that there is but one force emanating from the sun which is

the cause of light, heat, electricity and chemical action. The exact form of manifestation of this force is dependent upon the nature of the vibration, and I have attempted to illustrate this by the diagram I now show you.

You will see how the lowest forces and the coarsest vibrations correspond with electricity. Next come the infra-red or radiant heat waves. Then the various light waves up to the violet, and in this portion of the vibrations probably stand Blondlot's N-rays. Next come the ultra-violet, and then, separated by a long distance from these last, come the Roentgen rays. By the side of this table I have placed a line of vibration to show how a diminution of amplitude occurs all along the line.

The next diagram is intended to save a good deal of explanation regarding the action of the various rays. It is to a great extent self-explanatory. I would, however, like to point out to you that it is the ultra-violet rays which are destructive to germ life. It is reasonable to assume that it is by the profound agitation to which the bacteria are subjected by these rapid vibrations that the death of the germ is brought about. The physical agitation in its turn gives rise to a chemical process which ensures the death of the bacilli. It is probably correct to look upon each form of matter as having its own particular rate of vibration; organic matter has this property equally with inorganic, and the cells of the human body are of course included in the former category. It is possible that cells of the lower forms of life, and also cells of the primitive type in man—and among these may be classed embryonic tissue and malignant cells—evinced a lower rate of vibration than those of the higher tissues. Likewise cells or tissues in a state of disease may be the subject of vibration of a lower order than when in a state of health. If these surmises be correct, they will explain for us many of the therapeutic actions of light. In this way we may account for the destructive action of ultra-violet rays upon bacteria and malignant disease, whose rate of vibration is below that of these rays, and might be represented by—let us say—the vibrations in the red or yellow region of this section. To this

some may reasonably object on the score that long extended and excessive use of the highest known form of light, namely, X-rays, will not rarely produce cancerous changes in the tissue subjected to their influence, but this fact, rather than conflicting with, can be made to support the above view, for it is by first destroying the healthy tissues, which are eventually replaced by a form of cells, the vibrational swing of whose atoms is of a far lower order, that the malignant generation is brought about.

We can also see how, by submitting a patient whose tissues are diseased, or exhibit a loss of tone, to a series of vibrational light activity of grades somewhat higher than the vibrations existing in his cells, we may raise their energy and so bring about a relief or cure of the morbid state.

A few words here on the action of light in metabolism. The following facts are of importance, and may be taken as thoroughly established by experiments:—

(1) Various tissue cells—pus, blood, muscle, &c.—absorb more O in light than in darkness.

(2) Oxidation in the tissues is increased by light energy.

(3) The amount of CO_2 eliminated is in direct ratio to the intensity of the light.

(4) Persons and animals to whom daylight is accessible excrete more urine, urea, and chlorides, than those who stay long in the dark.

(5) Under the influence of light, through stimulation of the retina, marked elimination of CO_2 and consumption of O takes place.

(6) Absence of light retards metabolism. This explains the fact that starving animals, and even men who are deprived of food by the exigencies of life, exist longer if they may remain quiet in the dark.

It would seem from the above that the vibrations of the ether, which we call light, so act upon the cells of the body, that they are enabled to seize hold of the O atom with greater ease, and thus bring about a more powerful oxidation of the tissues.

It can scarcely be doubted that this takes place primarily through the blood. If we take the oxygen carrier of

the blood, viz., hæmoglobin, and examine it with the spectroscope, we see that it mainly absorbs the blue-violet and the ultra-violet rays. This is tantamount to saying that its own rates of vibration correspond to those of these rays, and it is highly probable that the same rates of vibration are in harmony with those of the oxygen atom. The cells of the body raised in their vibratory energy by the blood thus brought to them to a frequency corresponding to that of the O atom, are now in a position to absorb the latter, and hence occurs an acceleration of the metabolic changes.

This train of thought can be carried still further. Thus, inasmuch as some diseases are entirely dependent upon the inability of certain cells to grasp certain chemical atoms essential to their welfare (I mention anæmia in its relation to iron as one, but there are probably others in which organic salts, especially sodium and potassium, play a part), may it not be that this inability to attract and incorporate these atoms is due to the lack in the cells themselves of the vibrations which harmonise with those of the elements they require, and that by supplying the cells with the vibrations through light energy, matters are adjusted and a cure wrought. This does not appear such a fanciful theory if we regard the immediate and beneficial action of sunlight upon such diseases as anæmia and neurasthenia.

Further still, may not this vibrational activity explain the action of our remedies, especially those from the vegetable and animal kingdom whose medicinal properties, the outcome as they are of vital actions, are more immediately associated with the sun's energy than are those of metals and other inorganic substances.

This is a subject which will bear much thought, but I will not weary you with further discussion of it now, and will pass to the more practical part of my paper.

METHODS OF APPLYING LIGHT ENERGY.

The chief methods of applying light energy to which I desire to draw your attention to-night are : (1) The direct

solar rays; (2) the arc light; (3) the incandescent light; and (4) the mercury vapour lamp.

It is impossible in the time at my disposal to discuss the application of X-rays and radium. This is to be the less regretted in that the forces given out by them are in some respects different from those of light energy.

The above methods can be applied either to the whole body, or localised to a part. Thus in the case of the solar rays an entire sun-bath may be given, or the rays may be concentrated by means of reflectors or lenses to the portion of the body to be treated.

Solar Energy.

As shown by the solar spectrum the sun is a source of all the frequencies of visible light vibration, as well as a large quantity of radiant heat and ultra-violet rays. The latter are not found in large quantities at the surface of the earth and may be almost absent in towns. This is due to their absorption by the earth's atmosphere and suspended solid particles, such as dust and smoke in the air. At the seaside and on mountains their absorption is much diminished; consequently, in this situation a larger quantity of ultra-violet rays reach the earth, and as these are the most active of all rays on the skin, the effect of the sun's action is here more marked. Those of you who have been in Alpine districts will appreciate this.

Various forms of solaria, or sun baths, have been invented. On the screen is shown a simple method of getting a sun-bath, though the fact that a window is placed between the source of light and the body to a certain extent prevents the action of the ultra-violet rays which are only capable of passing in the smallest degree through glass.

A knowledge of the physiological action of sunlight is essential to its proper application, and I have already partly considered this point and will only add a few more observations here. It will be necessary always to bear in mind that the principles which govern the administration of the sun's energy govern that of other forms of light baths.

The heat rays of the sun will give rise to an increase in

the body temperature. The heart, brain and other organs will be stimulated, and there is an increase of metabolism. The sweat glands, likewise, and the cutaneous capillaries are dilated, but this is evanescent as compared with the dilatation produced by the ultra-violet rays.

The rays at the blue and violet end of the spectrum produce both stimulation of the sweat glands and marked dilatation of the skin capillaries. This vascularisation is of a much more persistent nature than would at first sight appear, as proved by an experiment by Finsen. He submitted his arm to the action of light, so that an intense erythema was produced. This disappeared in due course, but six months later, when at his toilet, he found that by rubbing his arm with a towel he produced a much greater redness of the skin over the part that had been previously inflamed than over the adjoining areas.

The obvious bearing of this is the value which light energy thus applied would have in those numerous diseases which, if not directly dependent on, are largely aggravated by, contracted skin capillaries. Further, the eliminating effect of the copious sweating is of the greatest service in all forms of toxæmia, as are the metabolic changes in diseases characterised by defective oxidation of the tissues.

For a tonic effect a short exposure of the nude body is required, but for eliminatory or metabolic action a prolonged exposure is necessary, due care being taken that the head is protected from the direct solar rays.

The Arc Light Bath.

In this country, especially in towns, it is often impossible for many months to obtain sufficient sunlight for bath purposes. In such a case the arc lamp energy may well be substituted for that of the sun. In cases where we desire to get a maximum effect upon the metabolism the arc light is even more suitable than the sun, for we are able to utilise all the ultra-violet waves in which its light is so rich without any loss such as occurs in the passage of sunlight through our atmosphere. Hence, for purposes of skin treatment, the arc light is always more suitable than sunlight. In addition to

this, when the arc light is used, a considerable amount of ozone is produced which is not without its effect upon the patient.

One method of applying the arc light in a cabinet is shown in the next slide. It can also be used in combination with the incandescent light bath, such as the "Sunbeam Bath" made by Mr. Holmquist, of Edgware Road, which is exhibited in the room.

When a patient is put into one of these arc light baths, the first effect is upon the skin, which begins to tingle slightly. Upon this follows an erythema which is more marked in some patients than in others. Slight sweating may occur after prolonged exposure, and an increase in the body temperature of 1° to 3° occurs. The bath itself is not a hot one, and it is necessary to warm the room in winter so as to prevent chilling. The pulse is not markedly accelerated; sometimes it is slowed. The duration of the bath is from 10 to 45 minutes.

INDICATIONS.

(1) *Tuberculous Diseases*.—The action here is partly bactericidal and partly through increased oxidation and increased nutrition. If we picture to ourselves the constant passage through the skin capillaries of blood and its corpuscles, each of which absorbing these rays of high vibrations with consequent increase of its O carrying power, we can form an idea of the amount of increased oxidation power which is obtained during a bath of even twenty minutes. It is the experience of all those who have used these baths in both acute and chronic phthisis that the patients have benefited by them. The only contra-indications would appear to be when hæmoptysis is a marked symptom; but even here Babbitt has found them of immense service in stopping the bleeding if a blue light is concentrated on the thoracic walls. The first improvement usually relates to the cough and expectoration, and then follows an increase of tone in the system and a gain in weight.

(2) *Neurasthenia*.—Dependent as this disease usually is upon some form of chronic toxæmia, it is only reasonable to

expect that the arc light baths with their chemical action would be of service. Personally, I have found a combination of the arc light and incandescent bath to be an excellent mode of utilising all the light vibrations in this malady. After each bath a ten minutes' application of the high-frequency current on the couch is useful. It is matter of common observation that neurasthenics have a natural craving for sunlight and fresh air, and are always better when out of doors, especially if sitting still and basking in the sun. In some cases they crave for some particular colour, mostly red or yellow, and symptoms such as those are worthy of note and should be utilised when possible. In such cases a bath of the desired colour made by filtering the light through red or orange glass is extremely useful. In other cases, when excitement of the nervous system is a predominant symptom, baths of blue or green light are indicated.

(3) *Anæmia and Chlorosis*.—The chronic state of sub-oxidation which characterises these conditions would suggest the use of light treatment. There is no doubt that hæmoglobin is increased by the action of light in addition to the other slow changes above mentioned, and in accordance with this these diseases are always benefited. On the other hand, light treatment does not seem to have any effect upon pernicious anæmia.

Other diseases which have been relieved or cured by arc-light treatment are eczema, nasal asthma, nocturnal enuresis and diabetes. The latter is upon the authority of Strebel, who treated a series of cases by focussing the arc light on the hepatic region. In a short time a disappearance of sugar took place.

It should be mentioned that by focussing the arc-light rays upon the nerves affected by neuritis much relief is often obtained and occasionally a rapid cure results.

Incandescent Light Baths.

One of the most efficient forms of bath is that exhibited.¹ It has the advantage of being used both with the arc and

¹ "The Sunbeam Bath," made by Holmquist, 57, Edgware Road.

incandescent light. It is easily cleaned, and inasmuch as the patient can be sponged whilst in the bath, it is more convenient than others in which this cannot be done.

The incandescent light is poor in the blue and violet vibrations, and ultra-violet rays are practically absent, but it is rich in the red, yellow and green. The action of these baths on the body differs in some respects from that of the arc bath. It is a question chiefly of the thermal action of the former as contrasted with the chemical of the latter, due to its richness in the blue and ultra-violet rays.

The action is chiefly upon the sweat glands, and the body temperature, which usually rises 2° or even 3° . The pulse also rises in rapidity, often going to 120 after a quarter of an hour's bath. There is sometimes an immediate fall of tension, but often the tension rises at first to fall some hours after the bath. The dilatation of the skin capillaries and the rise of body temperature both conduce to a greater metabolic activity. The body weight may be decreased in the case of obese people, but in the case of one of my patients who suffered from chronic asthma, and was very thin, a course of about twenty baths with incandescent and arc lights combined, producing very free sweating, resulted in a gain of $\frac{1}{2}$ lb. There is often a loss of $\frac{1}{4}$ lb. to $\frac{1}{2}$ lb. at the time of the bath, due probably to loss of water in the sweat, which is rapidly regained. At the same time this form of bath should not be given in the case of any one much enfeebled, or patients suffering from active tubercle. In such the chemical action of the arc light is indicated, and is usually followed by marked benefit.

These baths find their *rôle* chiefly in diseases of metabolism and toxæmias. Gout and rheumatism are much benefited by them. The alkalinity of the blood is increased, and there is a more active oxidation of the tissues. In certain cases of surgical tubercle they are also useful. They are contra-indicated in organic heart disease, advanced arterial sclerosis, and in active phthisis, especially if there is hæmoptysis.

I should now like to say a few words concerning the use of coloured light in the treatment of disease.

One of the earliest records in modern times of the use of red rays was made by John, of Gaddesden, a medical writer who died in 1361. "He treated the son of Edward I. for small-pox by covering him with scarlet blankets and a red counterpane, placing him in a room in a bed with scarlet hangings, gargling his throat with mulberry wine and making him suck the juice of pomegranates, and the patient recovered, never showing any trace of small-pox."¹

It is hardly necessary to say that as a result of this good John of Gaddesden had the distinction of being treated as a quack and a charlatan by his orthodox medical *confrères*. He, however, appears to have had a sprinkling of imitators in after years, for in Queen Elizabeth's day the virtues of red curtains, red coverlets and red glasses about the bed in small-pox cases were loudly proclaimed. Various medical men, up to the time of Finsen, also wrote on the subject. The latter observer, however, studied the matter carefully by experiment, and came to the conclusion that the red acted by shutting out the so-called chemical, or blue and violet rays, which undoubtedly act injuriously upon the small-pox vesicle, hastening suppurative changes, which do not usually take place if the blue light be excluded.

The same principle of excluding the chemical rays is followed by those who, having suffered from sunstroke, wear red linings to their hats and red-coloured underclothes. With these precautions they can go out into the sunlight with a certain amount of impunity.

We must distinguish this form of coloured light treatment from that in which certain rays are used for a specific purpose. This method has been advocated from the earliest times, and, as mentioned in the introductory part of this paper, it had been elaborated by Pancoast, Pleasanton, and more particularly by Babbitt.

There are few of us who have not at some time or other been affected by colours, and that these have a reflex effect upon the nervous system must be admitted. Red is often spoken of as a warm colour; blue as a cold one; green is restful, and yellow cheerful. Different people are differently

¹ Margaret Cleaves. "Light Energy," p. 588.

affected by colours, which probably means that each has his own rate of vibrations and is most in harmony with the same class in the outside world. We are fortunately not all, as is the bull, made maniacal by a red rag; but that red can rouse man to an extreme state of excitement is shown by the fact that in many photographic factories, where work has to be carried on in rooms lighted through red glass, the intense nerve excitement and irritation produced among the workers necessitated a change to green. Likewise small-pox patients treated in red rooms sometimes become excited and delirious.

Prolonged sojourn in a green-lit room, which is at first pleasant and soothing, becomes later very oppressive. Psychic processes are retarded and mental quietude results. Blue and violet light are even more depressing, and a melancholic and dreamy state soon develops, and often headache supervenes. In this connection I may mention that a patient whom I treated with the blue light focussed on the side of the head for furunculosis in the ear used to feel very drowsy whilst under the rays.

Upon the above facts hinge the principles of chromotherapy. Maniacal patients are treated by confinement in blue-lit rooms, and the excitement rapidly declines. Conversely melancholic patients are put into cheerful red and yellow rooms. Anæmic and chlorotic patients are treated by red light. In cases of local diseases, excess of action, such as inflammation, as well as local neuralgias, are treated by concentrated arc or sun-light, filtered through blue glass, and for this purpose Babbitt had glass globes of different colours by which the light might be focussed on to the part. The globes contained water, and after the treatment the water was given to the patient to drink, as Babbitt considered that the water contained the properties of the coloured rays which had passed through them.

The Use of Ultra-Violet Rays.

These rays have already been considered in connection with sun and arc light, and mention has been made of their action on the body. I only speak of them now in association

with the new mercury vapour lamp which has lately been put on the market. Hitherto, the difficulty of applying the ultra-violet rays has lain in the fact that the vitreous walls of the lamp, if made of glass, prevented the rays from reaching the patient. Quartz allows the rays to pass, but there are difficulties in the way of making lamps of quartz. The introduction of a patented preparation called uviol has done away with these difficulties, since it is pervious to a large proportion of the ultra-violet rays, so much so that a ten minutes' application of the lamp at close quarters will produce a marked erythema of the skin resulting in a bad sun-burn.

This lamp finds its chief uses in skin lesions, such as chronic inflammation, eczema, psoriasis and boils. Each of these I have treated with satisfactory results. There is another application, which I discovered a short while ago. Thinking that as blue rays acted as a sedative, and believing that these rays would therefore act in a still stronger manner to quiet the excited heart, I decided to try them in a case of exophthalmic goitre with very rapid pulse—(130 per minute). By the chart I now show you will see that there was an immediate effect, the pulse after ten minutes being brought down to 98. This steadying action on the pulse was repeated on each occasion, though it never, after the first sitting, went up to the original height. Some of the other nervous symptoms were at the same time relieved, but there was practically no change in the size of the gland itself. In another similar case in which I tried this plan the good effects produced in the first were not repeated, though I cannot at present say why one was so greatly improved and the other not at all.

I have used the lamp in association with X-ray for rodent ulcer with very good results; and a case of tuberculous induration and ulceration of the auricles and scalp, has made rapid progress in healing under the use of this lamp uncombined with other treatment.

Dr. A. E. HAWKES (in the chair) said the members had listened with intense interest to the author's lucid paper. He was gratified to

feel that one of their own therapeutic persuasion had so thoroughly studied this subject as to render metropolitan homœopathists independent of aid from those who otherwise differed from them, and had demonstrated, as was so often the possibility, that in London homœopathists were self-contained. He congratulated Mr. Wright upon his lecture, and the members who had had the pleasure and satisfaction of listening to it.

Dr. JAGIELSKI said that many of the members would remember that six years ago he brought the subject of electric heat and light before the notice of the Society, and gave an exhibition of the apparatus invented by Dowsing. At the time he had at his private house the Dowsing heating apparatus, and stated what an excellent thing it would be if the apparatus could be installed at this hospital, and he was pleased to say it was now. At that time the Princess of Wales, the present Queen, had not made her gift to the London Hospital, since which wonderful results had been achieved in the treatment, not only of lupus, but other complicated diseases of the skin. Thirty years ago, when he went to Manchester, he inspected a sunlight bath on the top of a house which was similar in character to a photographer's studio. It was interesting to remember that the sun produced an elevation of the temperature, and with the incandescent light baths a rise of temperature from 98° to 104° could be produced in fifteen or twenty minutes. It was also a remarkable fact that in fifteen, twenty or thirty minutes after the bath, without the application of cold water, the temperature went down to its normal state. Some old people, when they came for treatment in winter, had a very low temperature, and he could not understand how it was that the clinical thermometers in use only registered from 95° . They ought to register as low as 88° , and even lower, because he had seen the temperature, after cold baths, go down to 93° and 94° in half an hour. He thought the members were deeply indebted to Mr. Wright for the interesting lecture he had given.

Dr. NEATBY said that the author had made use of his name in connection with the heat treatment, but he was afraid that he could only follow him at a very long distance, and consider himself simply as a pupil. He had read Miss Margaret Cleaves' book, to which Mr. Wright referred, and had thereby obtained some glimpses into the facts brought forward. The very few remarks he desired to make were of a practical, and, he must confess, of an empirical nature. The class of cases which he had submitted to the light treatment had necessarily been some-

what limited, having all, in some way, been associated with gynaecological ailments, or patients who had come to him for that reason. One of the first patients that he submitted to the light treatment was a lady, forty-eight years of age, suffering from menorrhagia at the time of the climacteric. She, unfortunately, contracted influenza, and came back to him in a very depressed state of mind, because she was quite unable to pursue her very important calling in life, namely, that of a lecturer in a college affiliated to the London University. She was absolutely unable to use her mind; she could not read without getting confused, and having pain in the head; she had extreme sleeplessness, and general physical weakness, inability to walk, and so on. She also had the perspirations of the climacteric very pronounced. Acting on the suggestion obtained in a conversation with Mr. Wright, he gave the patient a course of twelve light baths. During the series, she expressed herself as very much pleased with the result of the treatment, and said that she was feeling better. She went away to her home in the country to complete the cure, and subsequently he received from her the laconic message that she was "quite well." He afterwards obtained more details, and the patient then told him she had less of the symptoms immediately following on the baths. He had had one or two similar cases of the kind. In connection with the effects produced, Mr. Wright had pointed out that the temperature rose, and had incidentally referred to the rise of the pulse. In his own experience, the pulse rate was of more importance than the rise of the temperature. It was necessary to watch the pulse rate extremely carefully, because patients were affected so very differently by light in regard to the rate of the pulse. One point of importance was that care should be taken to make the patient rest afterwards for a quarter, or, if necessary, half an hour. He had had some failures with the baths, the only feature in connection with which was that he noticed the pulse rate did not go down after the rest to below the original rate. The pulse was taken before the bath, every two minutes during the bath, and two or three times after the bath. The pulse-rate after the bath ought to be lower by several beats, four, six, or eight, than before the patient entered the bath. In the cases where he had had marked failure the pulse remained still above the original height. What the reason of that was he could not say. He had had some failures in deep-seated pains in the ovarian region, what were clinically known as ovarian pains. He thought that was perhaps explained by some of Mr. Wright's remarks as to the

want of penetrative power of the blue light. In neurasthenic cases, associated either with anæmia or amenorrhœa, and in some cases with menorrhagia, he had had some very good results indeed. A university student, who was a bachelor of science, came to him complaining of backache and menstrual pain, and with neurasthenic symptoms very much like in the first patient he mentioned, although she had not had influenza. The patient also experienced a similar benefit from the treatment; the pain in the back went away, and mental vigour was restored. In those two cases he noticed the average rise of pulse during the series of baths was twenty-seven, and in each case the pulse went well below the original number. In another case a patient came to him because she had suffered from repeated miscarriages, and was in a very low condition. In conjunction with some medicinal treatment which he prescribed, the patient also had a series of baths with the green light. The general symptoms of backache and weakness, which she had had for a considerable number of years from the series of miscarriages, disappeared. Curiously enough, the patient again became pregnant, and had already advanced to a considerably longer period of pregnancy than she had done for several years previously. The miscarriages had previously taken place about the tenth week, and the patient was now in the twentieth week of pregnancy. He desired to re-echo his own personal indebtedness to the author for his most exhaustive and fascinating paper.

Dr. MADDEN asked the author whether he would try and make a point of observing if the treatment by light could be shown to follow the law of *similia similibus curantur*. In the case of X-rays, something in that direction had been noticed in the production of cancerous dermatitis, and it was in its application to cancer of the skin that the X-rays had produced their greatest successes. He thought it was highly probable that, if only sufficient was known of the subject, it would be found that all similar applications followed the same principle, and if that were so it would be most encouraging to homœopaths, and add one great argument to their faith in homœopathy. He would also like to know whether the forms of light had been used on healthy persons or only on invalids? It would also be very helpful if the author could suggest how to differentiate between the use of the X-rays and the other applications of which he had spoken, such as the ultra-violet rays. It seemed to him they were both used in very much the same sort of cases with the same results. He had noticed the statement that they were of great

value in tubercle. When he was in Bruges recently, the doctor at the hospital there, who had been taking up the question of the X-ray treatment of consumption, showed him some photographs which indicated the wonderful improvement which had taken place, both locally and in the whole constitutional conditions, by exposing tuberculous patients to the X-rays, applied locally over the affected areas.

Dr. ROBERSON DAY remarked that chorea was markedly influenced by the light of the sun, a light which was rich in ultra-violet rays. Clinically, chorea was known to be uncommon in the autumn, but as winter advanced more cases occurred, until soon after Christmas it became a common disease. This year, as far as his own experience went, chorea had been rare, which he attributed to the fact that there had been an unusual amount of sunshine during the past winter. Some very interesting experiments had been made in Germany with reference to the nerve energy of children attending public schools. By means of a simple instrument, known as the *æsthesiometer*, an instrument like a pair of compasses in which the two points could be either widened or brought near together, the acuteness of perception of the skin had been tested, and it had been found that children were much more acute in their reception of tactile impressions when they were fresh, after vacations, and especially after open-air expeditions. Confinement indoors and study quickly reduced the amount of acuteness. Those experiments were exceedingly interesting, because it was possible to reduce them to a curve of intensity, varying exactly with the amount of energy that had been taken out of the child, the energy being quickly restored during rest, and especially after vacations and plenty of sunshine. These important facts should be borne in mind when arranging the school holidays, which, as at present existing, are a mistake. The long Christmas holidays, which are positively harmful to the children in our climate, should be shortened, and the same applies to the Easter holidays, though to a lesser extent; by some general rearrangement of the work, it would be possible to give the children the full benefit of our summer, which at the best of times is all too short. Instead of keeping the children indoors at school during the long days of summer they should be in the open, and taking full advantage of what sunshine we have. There would then be less need for the artificial light treatment. Mr. Wright had also given an explanation of how good it was to look at things *colour de rose*, and how sad it was to look at things through blue spectacles.

Dr. BEALE had for many years been interested in the subject of light and colour, and it was some years since he obtained the coloured lenses the author referred to. He had thoroughly satisfied himself that water enclosed in a yellow glass, and exposed to the sunlight for a few days, was able to acquire aperient properties. Babbett mentioned that in his works, and he (Dr. Beale) had tried the experiment, and satisfied himself more than once as to its correctness. It was not an individual but a general experience of the real benefit which was obtained by patients lying out in the sunlight, and, wherever possible, it had been his practice to suggest the use of sunlight baths to people in a low state of health, and he had found, especially in tuberculosis and rheumatic patients, great benefit had resulted. With regard to the practical and philosophical application of the subject of colour and light, he thought a great field of enquiry remained open in connection with homœopathy itself, because, after all, the substances from which medicines were obtained were nothing else than crystallised light; and when the subject was able to be properly investigated from that standpoint, he thought a great amount of information would be obtained which would be a guide to the use of certain remedies in particular diseases.

Mr. DUDLEY WRIGHT, in reply, thanked the members for the very kind reception given to his paper. He was particularly glad to hear Dr. Neatby's remarks on the subject of pulse, and he would make it a particular point to observe what action the light had in that connection. He was quite certain personally that it would not be difficult to reduce all physical actions in disease to the law of *similia similibus curantur*; but it was a question really of the difference of the action on healthy and diseased structures; as well as a question of vibration. The more he thought of it, the more he was convinced that the action of homœopathic remedies was just the same; it was a question of the vibration of the atoms of the medicines which acted upon the molecules of the cells, and it was in that direction that Dr. Babbett's researches went. Dr. Babbett, although he was not a true homœopathist, showed that the drugs used by the homœopath were all acting upon those lines. The paper which Dr. Percy Wilde read some time ago, on Energy in Relation to Therapeutics, dealt with this subject to some extent, and it was for that reason he had not touched on the question. With regard to the X-rays and the ultra-violet rays, the former were much more penetrating; they undoubtedly went deeper, and, with a hard tube, a very deep impression indeed could be made. At the same time, with the

greater penetrating force, they caused a much greater destruction of tissue than did the ultra-violet rays. For that reason they had a more rapid action on cancer of the surface, but they had their drawbacks in that they might produce destruction of healthy tissue. On the other hand, the ultra-violet rays probably had a much milder action on cancerous tissue and removed it at a slower rate, and it was yet to be ascertained which, in the long run, was the better agent for the cure of the disease.

THE THERAPEUTICS OF TAR AND ITS CONSTITUENTS.¹

BY P. PROCTOR, L.R.C.P.

President of the Liverpool Branch of the British Homœopathic Society.

EVERY stage in the history of medicine is characterised by the dominance of some particular theory of disease, with its corresponding treatment, and the period we live in will undoubtedly be regarded by the historian as that of the germ theory of disease and its corresponding treatment by antiseptics. What had been previously held inferentially has received confirmation by the microscope, and it is no longer possible to doubt the enormous influence of these minute particles of living matter and their injurious activity. We have, however, two factors in the case, the germs and the body they grow in. Both seed and soil have to be taken into account.

Whilst the profession at large is occupied, for the most part, in finding out directly-acting germicides, we homœopaths, whilst availing ourselves of these agencies whenever possible, endeavour to call to our aid the vital reaction by specific stimuli, thus giving us the advantage of a double attack on the enemy. Now to-night we are not going to consider tar and its constituents as antiseptics, but as homœopathic remedies.

Tar, as we all know, is produced by the imperfect combustion of wood and coal, giving us two varieties, having properties in common, with slight differences of chemical composition which I shall not dwell upon. There are two

¹ Presented to the Liverpool Branch, March 8, 1906.

natural products closely allied to tar, viz., bitumen and petroleum, and they may all be considered under one head. They possess one quality in common, the property of separating into lighter and heavier bodies by distillation; naphtha, benzine, eupion, guaiacol, phenol and creosote being among the lighter, and pitch, naphthalin, vaseline, izal and hard paraffin among the heavier bodies. Fortunately, we have provings of several of these that we can refer to for homœopathic purposes. In employing them medicinally it is open to discussion as to whether the results are due to their antiseptic properties or otherwise, but when we get the curative effects in accordance with their pathogenesis, and by means of doses too small for germicidal action, I think we may fairly claim that they have acted dynamically on the bioplasm. When, however, large doses are used it may be difficult to determine how far the germicidal and the dynamic powers are to be apportioned, and in some cases both properties may be brought into action, a combination not without its advantages.

The earliest reference to tar as a medicine that I am acquainted with is in "Bishop Berkeley's Treatise on Tar Water," published in 1744, followed by a book on the subject by Thomas Prior, who details a number of successful cases treated by it.

The Bishop's treatise is a wonderful display of learning both of physics and metaphysics, in which latter we finally get lost towards the end of the book. But whilst he deals with his subject scientifically, he amazes one with the range of his knowledge of the science of the time. How he came to hit upon the chief antiseptic of to-day we have no information beyond the statement that in certain parts of America tar water is made and used medicinally. Anyhow, the treatment of fevers and various forms of blood-poisoning by tar water that he advocated differs in no respect from that of enteric by carbolic acid as employed to-day, and perhaps tar water may have some advantages over carbolic acid yet to be discovered. Certainly on board ship with a supply of Stockholm tar on hand, an excellent substitute for carbolic acid would be readily obtainable. A bust of the learned and

prescient bishop might not inappropriately be placed in the College of Physicians. It should be noted that wood or Stockholm tar is always to be understood as referred to by Bishop Berkeley, for coal tar was not known in his day, having issued since as a by-product in the manufacture of gas, which was non-existent then. It would seem that the internal use of tar has been maintained in America, for several preparations of it have been in popular use for catarrhs, and at present an excellent syrup is in the American Pharmacopœia, so that the traditional virtues have received the stamp of authority, and I see that it is included in the B.P.C.'s unofficial formulary, and is likely to be included in a future B.P. In the old Dublin Pharmacopœia of sixty years ago, there was an *aqua picis liq.*, and nearly all the foreign pharmacopœias contain preparations for internal use. The only preparation in the B.P. is the unguentum. As just said, from the attention that has been paid to this agent of late years, notably by Dr. W. Murrell in his work on winter bronchitis, it is evident that we have in it a valuable medicine, and it is only necessary to look round to see the extensive use made of it in one shape or another, whether as the crude drug or as some of its derivatives in affections of the lungs. My own experience leads me to place a high value on several of these preparations in catarrhal states of the pulmonary tract in special cases. Having got our tar preparations set before us we may ask what use they are to us homœopathically. On referring to our *Materia Medica*, we find excellent provings of petroleum, creosote, carbolic acid and eupion, and slighter ones of benzine, naphthalin, and hard paraffin. Of crude tar itself we have no proving that I am aware of, but we may infer its properties from its constituents, that readily separate from it by distillation. Now, it is not my intention to go over the entire symptomatology of these bodies, but rather to point out a few indications for their use that have occurred to me in practice. Upon a general survey we may say that tar and its constituents, one and all, act in moderate doses almost exclusively on the various mucous membranes, and it is for this speciality of action that they are so useful. On all

the mucous tracts they set up irritation with more or less acrid secretion, and, as might have been expected, the more volatile elements affect the pulmonary tract, and the heavier ones the alimentary. This is their general character in moderate doses, but of course with large doses, such as we often get in carbolic acid poisoning, we have pneumonia and other visceral inflammations, along with blood decomposition and nerve prostration. But these destructive provings are not within my scope at present. It is the moderate effects I wish to consider, corresponding to the milder class of diseases that we mostly have to treat.

Dr. Murrell found tar pills of one or two grains very efficacious in winter cough, and the syrup of tar equally so in teaspoonful doses three or four times a day, and my own experience bears him out. If you look up your provings of creosote, and prescribe syrup of tar in accordance, in your cases of catarrh and cough you will not be disappointed. For my own part, I am bound to say that creosote and tar syrup have given me better results in the cough remaining after influenza than any other treatment. These bronchial and laryngeal irritations are very intractable, and until I used one or other of these remedies I found nothing of much value except kali bich. The creosote was given usually in the strength of six drops of the pure creosote to six ounces of water, with a little syrup added, and teaspoonful doses three or four times a day given. This may seem crude homœopathy, and perhaps smaller doses might answer, but I have seen no reason for diminishing the quantity, except in special cases. The syrup always agrees with children and delicate adults, and may be given with confidence. If tar possessed no other value than as a cough medicine it would be inestimable. When we touch on creosote its range of action is extended. As a remedy in gastric affections it has quite a reputation of old, and along with carbolic acid it corresponds to certain acute forms of indigestion with flatulence, pain and nausea, with retching and vomiting. Their action extends to the bladder and genital tracts, setting up pruriginous irritation and acrid secretion; this latter condition being well-marked with

eupion, for which our colleague, Dr. Hawkes, has given it in some cases that he has recorded. As regards carbolic acid in particular, it is a favourite remedy with me in irritable bladder in old men with frequent urination at night, of probable prostatic nature. Drop doses of the first decimal are what I usually give.

And now let me say a word or two about petroleum. It was one of Hahnemann's medicines, and although its use is general now in various emulsions, I think its earliest employment was by homœopaths. It is characteristically a catarrh medicine, corresponding to a more chronic form than creosote does, and it is singular to find its use recommended in precisely those conditions for which it is homœopathically indicated. Our literature contains numerous cures by it of chronic catarrh of the air passages, and of chronic diarrhoea. Its general employment simply gives the stamp of popular approval to indications for its use as given in the "Chronic Diseases." It is demonstrably homœopathic, and the material doses in which it is useful only proves that material doses are wanted with certain remedies. As regards one other tar product, benzine, a case of poisoning by it was recorded in the *Homœopathic World* (April, 1904), in which the symptoms greatly resembled the eruption and mucous irritation of measles, for which it struck me as being a likely remedy, knowing the general bearing of its congeners on the mucous surfaces. With tar syrup, then, and with creosole, guaiacol, phenol, eupion, in the acuter forms of catarrh, and with petroleum in the chronic forms, we possess homœopathic remedies that are of wide applicability to those affections that are so common during our winters that they constitute the major part of the work of the general practitioner. It is from the conviction that these remedies have not had the attention paid to them that they deserve that has induced one to direct your attention to this one aspect of their therapeutic powers, leaving for the moment all consideration of their action in other directions on one side. Possibly they have been neglected by us from the universal ascription to them of merely anti-septic properties, but if we regard them in the light of their

provings we should be able to restore them to their rightful place as homœopathic remedies. In this capacity it is surely no drawback to their usefulness that their antiseptic qualities may be enlisted on our side at the same time.

THINGS NEW, BUT OLD.¹

BY CHARLES E. HAM, M.D. (LOND.)

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MY great difficulty, since promising to read a paper before the Homœopathic Medical Society, has been what subject to choose, as I am neither an allopath or a homœopath, but ploughing a lonely furrow.

It occurred to me, however, that it might be of interest to show how Homœopathic ideas, or what I take to be such, have invaded and still are invading the almost sacred domain of the older or allopathic school, and that so rapidly that in a very short time allopathy, as such, will have ceased to exist.

Looking back over the last hundred years all must surely see how much allopathic treatment has altered, and when we remember that in the reign of one of our queens the court physician was unable to attend her Majesty because he had taken on the previous night a dose of medicine, we should at least feel thankful that our lot has been cast in pleasanter times.

If Homœopathy has done nothing else, it has taught the older school to greatly modify its former treatment. Allopathy, as practised even ten to fifteen years ago, seemed almost hopeless, its chief aim being either to force the bowels to act—the more suddenly and forcibly this occurred the better—or else to assist the stomach to relieve itself in a direction opposite to that which was originally intended by nature. But when we examine what may be called modern allopathy, the enormous strides that the older school has made in the last few years are marvellous, and unless we are up and working it will outstrip us in the race.

It was when viewing the chaos into which treatment had

¹ Presented to the Section of Materia Medica and Therapeutics, April 5, 1906.

fallen that I came across "Ringer's Therapeutics," from which may be gleaned much useful information. I remember trying Terebinth in cases of hæmaturia, and was surprised at the effects produced. In several instances the bleeding was arrested, but the drug sometimes failed me, and I was often disappointed to find that the treatment so confidently recommended by Ringer would not always do what was expected of it. It dawned upon me later on that Ringer's "Materia Medica" bristled with Homœopathy; crude though it may have been, the principles were there. A very able paper entitled, "The relief of certain headaches by the administration of one of the salts of calcium," has been published quite recently in the *Lancet* by Dr. G. W. Ross, and in which the author describes these headaches as having the following characteristics: (a) they are present and most severe on waking; (b) they manifest themselves as a dull ache or as a frontal or temporal throbbing; (c) they are very chronic; (d) they are associated with a deficient coagulability of the blood. The subjects of the chronic form of this particular type of headache are usually of the lymphatic order. The expression is heavy and listless, the face full, and the eyes often puffy.

Other symptoms are also included which are commonly associated with this lymphatic headache: (a) alimentary—*anorexia*, nausea, pain after food, and constipation; (b) respiratory—cough and shortness of breath, but rarely expectoration; (c) cardiac—palpitation and hæmic murmurs; (d) genito-urinary—slight albuminuria and dysmenorrhœa; (e) central nervous system and mental—sleep is usually heavy, but the patient wakes less rested than before going to bed, or the sleep may be disturbed. Irritability combined with languor, and all degrees of mental depression are present.

Patients characterised by the above symptoms have been treated most successfully with the calcium lactate, and why? because, as far as I can judge, such patients have been treated on the homœopathic principle. It is quite true that the dose employed was a large one, namely, 15 grs. three times a day, but such a dose I feel certain is unnecessary, as

the greater part of the compound is probably not absorbed, and consequently only a very small amount gets into the circulation. Would it not have been better, therefore, to have given the drug as some homœopaths are accustomed to do, in higher and more potentised doses.

Quite recently another form of treatment (the opsonic), has arisen among the allopaths, and with such a guiding genius as Professor Wright at its head it is making rapid progress, in spite of all opposition. It has long been known that the polynuclear leucocytes are capable of taking up foreign substances and in some way or other of destroying them. Metchnikoff has shown that micro-organisms may be attacked in a similar way; and Wright has also proved in a number of brilliant researches, not only that the leucocytes are quite capable of digesting micro-organisms, but that the presence of some body in the blood is necessary to enable the leucocytes to fulfil their proper function, and these bodies he has termed opsonins. An accurate knowledge of the opsonic index is of great importance, and before going further it may be as well to describe very briefly the method by which the opsonic value of the blood is obtained. The method of procedure is simple: a mixture is made of equal volumes of the serum from the person under observation, of a suspension of corpuscles and emulsion of the organism. This mixture is incubated at the temperature of the human body for about ten to fifteen minutes and is then compared with one composed of a suspension of leucocytes and emulsion of the organisms as well as the serum of a normal person. Blood films are made from the mixtures, and after appropriate staining the number of bacilli or cocci taken up by the leucocytes is determined, and from these data the opsonic index may be found.

These researches are of more than mere scientific interest. Looking at them from a practical point of view they are of great value, for they have placed the diagnosis and treatment of chronic diseases produced by certain organisms on a satisfactory and rational basis.

Wright and his pupils have shown that the leucocytes of various individuals will not necessarily take up the same

number of a particular kind of organism—*e.g.*, tubercle—or, in other words, the opsonic power of their blood is not the same. This difference has nothing to do with the leucocyte itself, but is due to the deficiency of the opsonins circulating in the blood. The knowledge of these facts is of the utmost importance, as this deficiency of the digesting power of the leucocyte for tubercle, or, in other phraseology, the diminished opsonic power to tubercle, is found and only found in patients suffering from some form of chronic tubercular disease. The treatment of such cases is very interesting and especially so to homœopaths. Koch, years ago, tried by injections of tuberculinum to cure tuberculous patients, but, as everyone knows, his results were far from satisfactory, though his principle was right. His failure was chiefly due to two causes, firstly, his dose was much too large, hence, instead of doing good it only aggravated the condition; and secondly, he did not pay sufficient attention to what is now known as the negative phase. After an injection of tuberculinum in fairly small doses the condition of the patient is really worse than before the injection, and the period over which this extends is known as the “negative phase,” and if more tuberculinum be given during this period the result may be disastrous.

Wright, on the other hand, begins with a much smaller dose, $\frac{1}{1000}$ mgr., and he does not inject a second before the negative phase is over, the termination of which is indicated by the opsonic index. The effects, therefore, that follow an injection are: firstly, a negative phase, the opsonic index at this stage being less than it was before the beginning of treatment; and, secondly, the gradual rise of the index to a certain maximum and its fall again to a little below that maximum, where, at this point, which is higher than the original opsonic index, it remains stationary. About this time a second injection may be given, and is continued until the opsonic index reaches the normal. The results thus obtained are excellent. I have seen glands of the neck disappear entirely under the small repeated injections of tuberculinum; cases of joint disease have also considerably improved under this treatment. Two patients of mine

suffering from tubercular cystitis, both of which were bad cases, are now perfectly well.

Not only may diseases produced by the tubercle bacillus be treated in this way, but conditions caused by other organisms can be as successfully removed by employing a similar method. One very striking case that I have seen was that of a policeman suffering from acne vulgaris, and who had been under treatment for several months without receiving any benefit. After some injections of staphylococci—I forget how many—the result was astonishing, the skin of his face became perfectly clear and he was able to follow his usual occupation. It can at once be seen how this new method of cure will revolutionise the treatment of the allopathic school, for it places the treatment of certain constitutional diseases on a sound pathological basis. There can be no possibility of denying these results, as cures of such chronic diseases have been and can be effected by such methods.

What would Hahnemann himself have said to all this? I believe he would have rejoiced to see this day; he would have revelled in the vast resources opened out by bacteriological discoveries. It can easily be seen in his work on "Chronic Diseases" that he was far from satisfied with his earlier discoveries. He was the first to acknowledge that the continued homœopathic treatment of non-venereal chronic disease was often unsuccessful. Why should homœopathy have failed in thousands of cases to effect a thorough and permanent cure for such chronic ailments? Let me quote from vol. i. of "Chronic Diseases": "These failures were, perhaps, owing to the small number of the homœopathic medicines whose sure action had been ascertained. The followers of homœopathy were satisfied with this excuse, but the founder of homœopathy rejected it as a mere subterfuge. For the early increase of powerful homœopathic medicines left the treatment of non-venereal disease in the dark, whereas acute diseases, provided they were not fatal from the beginning, were not only considerably alleviated by correctly chosen remedies, but even promptly and thoroughly cured by means of the

vis medicatrix of the organism." It was these facts that led Hahnemann to the discovery of chronic disease. He realised that underlying many complaints, which, although considerably relieved after a careful study of the symptoms, were not actually cured because of some already existing chronic constitutional condition. Who, when reading Hahnemann's work on "Chronic Disease," could but admire the genius of the man who, nearly 100 years ago, not only recognised, but treated with many good results, this deep chronic constitutional state or condition; he alone seemed to have fathomed one of the chief difficulties connected with satisfactory treatment.

Has homœopathy made any great advance since its founder's time? From what I can gather from the literature I think not. Swann and Burnett appear to have grasped more clearly than many the principles underlying Hahnemann's work on chronic disease. They saw, as did he, that there was something underlying a great many of the diseases which came under their notice almost daily, and that something must be cured before the perhaps well-chosen remedies would ever act, and grasping this principle they endeavoured perseveringly to follow in the footsteps of their great master. Burnett was more fortunate than Hahnemann, for he lived in a time when bacteriology was beginning to shape itself into a definite science, though even then it was in its infancy, but he realised its importance as shown in his treatment of certain classes of disease. His method was to obtain diseased material, potentise it, and give such potentised material to patients suffering from diseases similar to that from which the material had been obtained, and—if one may believe what he says—with good results. Even in more recent times one of the most prominent bacteriologists in London has treated patients very successfully by injecting material obtained from their own diseased tissues.

What astonishes one most is the manner in which this line of treatment has been neglected by homœopaths, for, except here and there, it has received the scantiest attention. It has apparently been left to the allopaths to demon-

strate the great importance of such methods. Not that one grudges for one moment the credit that has accrued to Wright, for he has not only perfected this line of treatment, but he has placed it on a firm and accurate basis. Nevertheless, it is only natural that there should linger in our hearts some feeling of regret that so many of the laurels should have fallen to the older school, when a few homœopaths were first in the field.

Burnett's work, from the modern scientific point of view, was far from perfect; his methods were decidedly crude—but we must remember that he lived in crude times—nevertheless, his work was in the right direction. Many of his cases are exceedingly interesting, for by the ordinary homœopathic remedies he was able to relieve the symptoms, and the patient became apparently quite well; but the cure, if one may speak of it as such, was not permanent, the trouble recurred and was, perhaps, again relieved by suitably chosen remedies. Why was this? It was because, as Hahnemann found, that underlying the whole condition was some constitutional defect, or, using more modern phraseology, some pathological condition which, in reality, had never been touched. Take, for example, a case of tubercular glands of the neck; they may be greatly improved by giving silica, but yet the constitutional condition underlying the whole trouble remains unaffected. It was by grasping this principle that Burnett was able to cure otherwise incurable patients.

How is it that homœopathy has not made the advance that would have been expected of it? It seems to me that the chief reason is that the supporters of it have lost sight of the laws laid down by their great master. Homœopathy, at the present time, appears to be divided into two schools, one of which claims that symptoms are everything and pathology valueless, whilst the other holds an entirely opposite view. That was not Hahnemann, he believed in the totality of symptoms, and the totality surely includes both. He, no doubt, laid greater stress on the symptomatology which can easily be understood, as, in his day, pathology was of the crudest kind; but surely there is

no reason why homœopaths should not utilise work that has been done since his time! It may be, that having been a pathologist myself I lean rather more to that side of the question, yet putting bias aside it seems to me that true pathology has been too much neglected and has not had its right place amongst homœopaths. Symptoms are undoubtedly most valuable, and I do not wish for one moment to underrate their value, but even they are really the outcome of some altered state or pathological condition, and it is the finer shades of pathology that are capable of producing such varied symptoms, which must be more carefully studied in the future. The opsonic work, I think, may be given as an example of such.

There seems to be a growing tendency, especially among the American homœopaths, to ignore pathology of any kind, and if such be the case, diagnosis must take a very secondary place, and many of the cures that have been described lose half their value. Let us take, for example, the report of an epidemic of diphtheria recorded by Professor Nash. He relates how none of the cases who persistently took apis ended fatally; but the faulty point in the whole account is that not sufficient care was taken to ascertain if the cases were really true diphtheria. Diphtheritic throats are often not easy to diagnose, and it is one thing to have cured cases of severe tonsilitis—a very creditable achievement too—but quite another thing to have saved all the recorded number of patients if they had been suffering from diphtheria. I am not saying that such an epidemic was not one of diphtheria, but I do contend that sufficient care was not taken as to diagnosis, and therefore the results were not nearly so valuable as they might have been.

Some of the cures related in Kent's "Materia Medica" are of a most extraordinary kind. Under arnica, he says, "it is quite a common thing for old cases of gout to rouse up into a new soreness of joints with great sensitiveness. You will see the old grandfather sit away in the corner of the room, and if he sees little Johnnie running towards him he will say, 'Oh! do keep away, keep away.' Give him a dose of arnica and he will let Johnnie run all over him."

It is possible that the dose of arnica may have brought about the rapid change of mind in the grandfather towards Johnnie; but one must remember that some gouty conditions disappear very rapidly, even without treatment, and there is no mention how long the grandfather had been troubled with this pain before taking the arnica, or how long after the dose of medicine Johnnie was allowed to run over him.

Again, in the article on Sulphur we read, "When attending the public clinic I have many times noticed that after sulphur an individual begins to take notice of himself and puts on a clean shirt, whereas his earlier appearance was in the same old shirt." Here again it is possible that the dose of sulphur may have had this purifying effect; but I think that such cases should have been further investigated, as there are often other causes at work besides a dose of sulphur in high potency which may bring about these profound changes. I believe, from what little I have seen of homœopathy, that there is a right principle underlying it, but it is of the greatest importance at the present time that all homœopathic research should be so guarded as to be impregnable to all possible attacks of an enemy.

There are, undoubtedly, two directions in which great advances may be made in homœopathy, and they are (*a*) the question of dose; (*b*) the value of the nosode.

In disease various symptoms arise, and I suppose such symptoms are the outcome of the struggle of the cells of the body to overcome the diseased condition. The object of all treatment, therefore, should be to give just such sufficient stimulus to the cells to enable them to come out victorious, and the dose aimed at should be of such strength that it will exactly bring about this desired result. If the dose be too strong, then, instead of doing good, even harm may be done, and I believe our medicines are often given too low and too frequently. This was years ago recognised by Hahnemann, and it is very clearly brought out in Koch's and Wright's researches. The question as to whether a 30, 200, or cm. is given will probably matter very little, as these high potencies act in all probability through the liberation of

their ions; and it is a well-known fact in physical chemistry that up to a certain point the conductivity increases the more dilute the solution be, owing to the better liberation of the ions, but that after a certain point has been reached any further dilution will make very little alteration, and the same may apply to the high potency of a drug.

The nosodes, although of great value, have been very imperfectly worked out. In the out-patient department here one has seen chronic tubercular conditions very much improved with tuberculinum even when given by the mouth, but these cases are at present isolated, as so few seem to have made use of these valuable remedies. Returning to Professor Wright's researches, it seems to me that he has given us a way by which the nosode may be more accurately studied, and at present we are endeavouring to ascertain if the opsonic index is raised after taking the nosodes by the mouth in a potentised form. It is quite conceivable that if such be taken in this way they may act quite as well as if they were injected. We know that bacteria are often destroyed by the acidity of the gastric juice, but the HCl will not necessarily alter the poison contained in the organism, and if potentised it may be easily absorbed and passed on to the cells of the body. The exact dose to be given has still to be worked out by experiment, and it is only by careful notice of the cases and watching the alterations in the opsonic power that this can be done. The dose given should just bring about reaction without aggravation, and, I believe, Professor Wright himself would get even better results if his preparation was of a more dilute nature.

If the nosode is to act well great care must be taken in its preparation, and I think sufficient attention is scarcely paid to this point, *e.g.*, in the case of medorrhinum. No one knows exactly the source of this substance, it is supposed to contain the virus of the gonococcus in a potentised form, but there is no certainty about it. Again the tuberculinum at present used is made from Koch's old tuberculinum, and this is acknowledged by most to be very uncertain in its toxicity.

Most of the nosode preparations were made before

bacteria was capable of being isolated, but since such is possible now, it would be far more reasonable to use young cultures of the organisms themselves which have been killed and potentised. With the aid of these nosodes, certain chronic diseases may be cured which would otherwise require surgical treatment. Surgery will then be robbed of much of its work ; yet one feels sure that every surgeon, or at any rate every homœopathic surgeon, will hail the day with joy when they can lay aside their knives and practise the gentler art of the physician.

There is a great future before us if we only use aright the truth that is ours by inheritance, but at the same time we must remember it is only by unity and dogged perseverance we shall succeed.

Dr. A. E. HAWKES (in the chair) said the meeting would not be likely to dispute a suggestion that the author of the paper was not sitting on a hedge. He thought Dr. Ham had left the uncultivated prairie for the ploughed fields which he saw before and around him. Soon after the publication of Beale's book relating to germinal matter, which some of them knew thirty-five years ago, it was suggested that it would long continue to bear fruit. It was pointed out long ago by homœopaths that the recognition of the ready way in which germinal matter absorbed this and that, would very likely lead to the discovery that it also had much influence over infinitesimals. Amongst the workers on nosodes Dr. Skinner, whom they knew so well in Liverpool, should receive mention. As regards tuberculinum, soon after Koch's experiments, he (Dr. Hawkes) asked Thompson and Capper to prepare for him some of the sixth dilution ; he was very well pleased with it, and had had some very good cases, though lately, perhaps, he ought to have used some other preparation, in view of more modern opinions. He had had a case of tuberculosis with the glands of the neck enlarged, in which the patient was not in a fit state to have them removed ; but recently, the patient having gone to a sanatorium, operation had been carried out with every hope of success. At Davos, under the direction of Neumann, much the same dilution that Dr. Ham had mentioned, namely, the millionth of a grain, was injected occasionally. A very obscure case was sent up to the London Homœopathic Hospital some time ago for diagnostic purposes, in which

osteomalacia was closely simulated. Some months after her return to Liverpool it became obvious that the patient was tuberculous; she then went to Davos, and is doing well under the treatment Dr. Neumann initiated at New Brighton. A while ago she could not walk, nor even stand; she now walks well and is gaining flesh. Dr. Ham draws a sorry picture of the surgeon of the future, when all the appendices shall have been removed and tubercular glands cured with tuberculinum. When that time comes, their surgical friends may have to fall back upon some other anatomical region, which he trusted might be as fruitful of benefit to suffering humanity as the regions to which at present they devote their attention.

Dr. DYCE BROWN thought Dr. Ham was perfectly correct on one point, namely, that there are two schools among homœopaths—those who go in for the pathological view and those who go in for the symptomatic view. He agreed, as he thought they all did, that pathology, and everything that is known at the present day, should be made use of with a view of diagnosing a case in the fullest particulars; but having done that, one could not but think that they had then the necessity of choosing medicine by symptomatology. Symptoms are the indication of the disease as it is seen, and under symptoms he included not only subjective symptoms, but objective symptoms as well. If they utilised all those symptoms, they got a much more accurate and trustworthy guide for the treatment of a case than if they were to allow any pathological view to interfere with their treatment.

Dr. GOLDSBROUGH asked Dr. Ham whether he could give any information as to the quality or character of what is called opsonin; what was its nature; or whether it was theory only of Professor Wright that there is such a substance in the blood serum which enables the leucocytes to absorb the toxins?

Dr. LAMBERT said the line Dr. Ham appeared to take with regard to nosode treatment is that practically no chronic disease due to microbes can be cured without the use of corresponding nosode, and he instanced the case of tubercular glands which might go away under silica, and yet the underlying condition not be cured. If that were so, a good many of their ideas would have to be very much modified; and he (the speaker) did not agree with Dr. Ham. He knew of a case of a young lady suffering badly from undoubted phthisis, which Dr. Skinner had cured absolutely with *calcareo carbonica* high without any tuberculinum at all. He had seen the patient since then and found no evidence of lung disease. Although before this cure several doctors had

seen her abroad, and had given a very bad prognosis. He quite believed they would find that the opsonic index was capable of being raised by indicated drugs without nosodes. Dr. Ham was at present testing this point at Dr. Lambert's request.

Dr. CLARKE said it was exceedingly interesting to him to have the question put as Dr. Ham had put it, coming so recently as Dr. Ham did from the other camp, because if anything would bring the other side to recognise the truth of the homœopathic principle it would be the nosodes. The farthest-seeing men on the other side were recognising that at the present time. Professor Wright, he knew, was entirely unbigoted in the matter of homœopathy and allopathy. Some articles had appeared in the Medical Press recently by Dr. Montgomery Paton on the internal exhibition of anti-diphtheritic serum, and of what was called simple plasma, that is to say, the serum of the horse without any diphtheritic element in it. The horse is very refractory to tubercle, and Dr. Montgomery Paton maintains that by administering by the mouth the serum of the horse he can transfer the degree of immunity possessed by the horse to any patient. The resistance of any animal to any disease is not absolute, so that we could not succeed in raising the immunity beyond the degree possessed by the animal yielding the serum, but up to that point we might expect to get results. Dr. Montgomery Paton's results were certainly very remarkable. On seeing these articles, he (Dr. Clarke) had written to Parke, Davis and Co., who were mentioned as supplying the serum, but they had informed him that they did not supply the simple plasma; they only supplied the diphtheritic; however, they had referred his letter to Dr. Montgomery Paton himself, who had called on him yesterday. It was quite interesting to him to find that Dr. Montgomery Paton was open-minded as to the homœopathicity of the action of these substances. Dr. Ham was rather hard on Dr. Kent about his cases; but then Dr. Ham, coming fresh from the old school, thought it was very necessary, as they all did once on a time, to do everything that was exact and convincing to the allopaths. However, when people got to the age of Kent and himself, they did not care a brass farthing for anything that allopaths might think, but went on with the work which they had to do. Kent, with his arnica and his sulphur, simply gave a graphic illustration of what they might expect arnica and sulphur to do, and if they took it at that, they would find that Kent was not far wrong. Dr. Ham, referring to the different preparations of nosodes, said they ought to be more exact in selecting their substances than had been

the case in the past. The pioneers who made the first nosodes were pretty careful to get nice virulent cases of whatever they went for, and they found that the remedies that they prepared were exceedingly potent. Now, if they had got the potency of the remedy, and if they knew what it would do and which cases it was suited for, they need not bother very much about whether it had this, that, or the other bacterium in it originally. Dr. Ham mentioned Koch's tuberculinum as rather out of date: that might be, but his preparation was a very valuable preparation in the homœopathic potencies, and the preparation Burnett used was also a very powerful anti-tuberculous remedy. He had often heard men say they preferred Koch's, because they knew what it was. It was not a case of preferring one or the other; it was a matter of getting the right cases for the one, and the right cases for the other. The bacillinum was prepared from virulent tuberculous sputum, and it contained not only the tubercle bacillus and its ptomaines, but also the suppurative bacilli, and consequently it had a wider range of action than the tuberculinum of Koch. Dr. Ham had divided the homœopathic field into two sections—the pathological and the symptomatic. That was very pretty and nice; but it was not easy to say to which side anybody really belonged. Hahnemann was far ahead of most as a symptomatologist, and he was also far ahead as a pathologist, and there was no pathology going now that beat Hahnemann's for fundamental practical utility. He thought Dr. Ham would find, as he got a little more experience, that the most careful symptomatic prescribers are also the most careful diathetic individualisers. Dr. Ham should bear in mind that the nosodes are exactly like any other homœopathic remedy. Men must get to know their indications very carefully, as the nosodes will work on their indications whether the actual microbe is present in the patient or not. Nosodes have a very much wider field than in the actual cases of disease, and very often in collateral cases they will do more than where the actual disease is present. In acute phthisis we should be less likely to get much good from tuberculinum or bacillinum than in cases of asthma, of enlarged glands, and in all kinds of illness associated with a tubercular diathesis. In cases of cancer, cancer nosodes often give excellent results, and they also give very brilliant results in cases of illness in cancerous families. He was very glad that Dr. Ham had brought the nosodes before the Society, because, unless homœopaths set to work and used nosodes and beat the allopaths on the nosode ground, the allopaths would go ahead of them.

Dr. ROBERSON DAY said some years ago he recorded in the London Homœopathic Hospital Reports the case of a girl who had a tuberculous ulcer upon the face, which, after being under allopathic treatment for eighteen months, came under homœopathic treatment. He treated her with tuberculinum 30 only, and in some six weeks the ulcer completely healed, and it had remained so, because he knew the patient at the present time. Since then he had used the nosode tuberculinum very extensively. He was delighted when Professor Wright published his work, because that offered an explanation of the *modus operandi*. The nosodes were not supposed to act homœopathically, but their action was termed isopathy. He had shown Dr. Ham that tuberculinum 30 given in weekly doses by the mouth, and nothing else, would cure tuberculous ulcers. They had several cases in the ward under observation at the present time, one an inveterate one, where the tuberculinum as prepared by Dr. Ham himself in attenuation was being administered, and it was producing very gratifying results. He had been rather surprised that they had not heard something of Dr. Constantine Hering, of America, who had been one of the pioneers in introducing the nosodes into practice.

Dr. MACNISH said the work of Drs. Burnett, Cooper and Skinner had not been fully appreciated by the members of the Society, and he was sure that if they made more use of nosodes, there would be many more brilliant results recorded in the annals of homœopathy. He had found them of the greatest value in the treatment of many diseases. There was a question whether this treatment was isopathic or homœopathic; personally he thought it was homœopathic. He hoped that this paper would, as regards homœopathy, raise the opsonic index of the members of the Society.

Dr. EDWIN A. NEATBY thought it was quite possible they might do better with the cruder nosodes, that is to say, with using the mixed organisms which are present in cases of phthisis, or in a case, say, of epithelioma that is undergoing degeneration, instead of using the pure culture. He also thought they could with advantage do that which had already been done in this school, namely, they could make the nosode from the individual case. In many instances the best way of getting the homœopathic remedy was to take the nosodes from the patient himself. Dr. Lambert had raised the question whether it was necessary to use the actual toxin of the diseased organism or whether other remedies would not act as well. He did not want to reply for Dr. Ham, but this was an important point, and he would like to

be allowed to give his own opinion. He thought that anything which would raise what, for want of better knowledge, had been called the vital power of the cells, the resisting power of the tissues, would act in the same way; but very often a nosode acted better than other remedies, because it was more strictly homœopathic to the case. There was a very interesting instance of this fact in connection with tetanus and strychnine. Tetanus was met in some instances by strychnine, but though strychnine would control some cases of tetanus, it did not do it by causing an anti-toxin to be formed, for though the symptoms are very similar, yet after the administration of strychnine had produced a condition very like tetanus, there was nevertheless no anti-toxin found in the blood. That was an instance where they did not get sufficiently near to the homœopathic remedy. They wanted to get the actual toxin of the disease which does produce an anti-toxin, but so far they had got no non-bacterial remedy which approached nearer than strychnine as a general rule. There might be cases of tetanus which were curable by some other remedies, but as far as he understood it, strychnine was the nearest. On the question of isopathy and homœopathy, it seemed fairly obvious that there was a distinct difference between the disease germ when inhaled in a case of diphtheria or phthisis, and grown in the patients' own tissues, and the germ taken from a culture in a test tube and injected. The difference was sufficient to make it, as far as he could see, true homœopathy. Moreover, in one case the micro-organism was dead, and in the other living and capable of indefinite multiplication.

Mr. KNOX SHAW said that in this paper there was no prescribing on the totality of the symptoms. The patient was treated on purely pathological lines. Having first made a diagnosis of tubercle, you do not ascertain his symptoms at all, but you give him a drug which is to meet the pathological condition. That was pathological prescribing pure and simple, and he thought that the reader of the paper would have been jumped upon at once. That Dr. Ham had disarmed all criticism, he thought, proved the eloquence of the paper and the strength of the argument. If the theories brought forward in the paper were correct, it seemed that there might be various ways of raising the opsonic index. It was quite possible that drugs other than isopathic drugs would raise the opsonic index, and experiment alone would show whether this were possible. It might be that one of the products of the tubercle would be the best drug to use, or it might be that such drugs as calcarea or iodide of

arsenic would be equally efficacious. If they could show that the opsonic index was true—and he was not prepared to admit that it was, although it appeared at present to be so—then it was worth spending a certain amount of time in endeavouring to find out whether drugs given by the mouth, as well as subcutaneously, would raise the opsonic index.

Dr. C. OSMOND BODMAN asked whether they could take the opsonic index as a reliable diagnostic help in obscure cases of supposed tuberculosis? If the index was lowered, could they deduce from that that the case was one of tuberculosis? Personally, he had been rather disappointed in the use of tuberculinum, which he had employed in a considerable number of cases, and a homœopathic colleague that afternoon had expressed the same opinion to him, but said that in other cases, not evidently tubercular, but where the symptoms seemed to fit in with tuberculinum, he had got satisfactory, indeed surprising, results. Were they in such cases to take it that there was an underlying tubercular element?

Dr. HAM, in reply, said with reference to Dr. Dyce Brown's criticism, he considered that prescribing Bryonia in cases of rheumatism and pleurisy, on the pathological basis of inflammation of the serous membranes, was valueless. That kind of pathology was too crude, they must get finer shades of pathology than that, and he believed the opsonic index was an example of such. Dr. Goldsbrough wanted to know the nature of the opsonins. He was afraid that at present he could not tell him, except that they were destroyed at 55° C.; *e.g.*, in a certain experiment the average number of tubercle bacilli taken up by a leucocyte was 4. The serum had been previously heated to 55°, the leucocyte now could perhaps digest only one. Evidently, then, as the serum used in each case was from the same source, something must have been destroyed in the process of heating this serum, and that something was the opsonin. Dr. Lambert said he had observed tubercular glands disappear without using tuberculinum, but some other indicated remedy *e.g.*, silica. That was quite possible, and indeed it was a well recognised fact. After drawing off the pus from breaking down glands, the patients might get apparently quite well. The point was whether the opsonic index was raised to the normal in such cases, and if not, then these cases could not be considered cured. It would therefore be interesting to find out if the opsonic index was actually raised by giving certain drugs. Dr. Clarke had said that the nosodes would act whether the bacillus were present or not, he

(Dr. Ham) did not know, but rather thought the reverse ; at any rate the action would not be so certain. In acute phthisis Professor Wright was entirely in agreement with Dr. Clarke. The opsonic index showed that tuberculin would be of very little value. Dr. Clarke believed that bacillinum was better than tuberculinum. Bacillinum is really a mixed nosode, it would in all probability contain some other varieties of organism besides tubercle, and under certain conditions this might be advantageous. An example of this was found in one of Dr. Ham's patients (tubercular disease of bladder). In this particular instance the opsonic index was lowered for tubercle and bacillus coli. communis, and to cure the patient, injections of both organisms had to be employed. He considered, however, that it was better to give them separately, and not in a mixture, as Dr. Burnett used to do. Dr. Day had spoken about the very good results he had got from giving tuberculinum 30 ; at present he (Dr. Ham) had only seen very few cases, and he was not very satisfied with the results. As to the difference between isopathy and homœopathy, he really was not sufficiently up in the subject to say anything very definite, but he rather thought the action of tuberculinum was on the homœopathic principle. Mr. Knox Shaw had found out that he (Dr. Ham) rather leant towards pathology. He had done a good deal of out-patient work lately, and he had found that to a man who was not well versed in homœopathy it was very tedious work attempting to prescribe by symptoms. If they could get some simple method such as an opsonic index, it would make things work easier. Dr. Bodman had asked if there was much value to be attached to the opsonic index as a diagnostic point. Dr. Ross at the Victoria Park Hospital attached great value to it. There were several cases where it was doubtful whether they were phthisical or whether they were cases of malignant endocarditis. Dr. Ross found that by the opsonic index he was enabled to make a definite diagnosis, and on *post-mortem* he had found his results verified. Both he and Professor Wright laid great stress on the opsonic index as a diagnostic aid. There had been a long discussion two or three years ago about the hereditary nature of tuberculosis. In a lot of those cases they would find that the opsonic index was lowered, although the patient had not definitely got tubercle. He thought by giving suitable nosodes they could raise the opsonic index, and so prevent tubercular infection.

NEW, OLD, AND FORGOTTEN REMEDIES.¹

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PART I.

THE practitioner of homœopathy who is "up-to-date" acquires for his daily combat with disease every weapon that can deal an effective stroke. Possessing, as he does, the key to drug-action, he ranges over the world, animal, vegetable, mineral, and even human, for his remedies, and verifies the saying of the classical writer—

"Magis venenum, magis remedium."

I observe an important difference in the growth of the pharmacopœias, or rather, the materia medica of the two schools of medicine.

Whereas the "old school" materia medica is being enlarged, if not enriched, by synthetic drugs, chiefly manufactured in German laboratories from coal-tar, and floated on the British market by vague testimonials, that of the homœopathic body is being recruited by Nature's productions, previously tested in disease, very often also on the normal human being, and thus has something like a definite value for us who try them for the first time.

The antitoxins of allopathy are in a different class, and though parallel to our "nosodes" are not included in my subject.

Who will deny that of the interminable series of coal-tar derivatives, many of them with "fancy" names which give no indication of their composition, few survive the ordeal of time?

In a year or so they are forgotten—

"They have their day and cease to be."

But *our* additions, fewer in number, and slower in coming, are either "proved" according to Hahnemann's method,

¹ Presented to the Liverpool Branch, April 19, 1906.

or have been, on competent authority, exhibited successfully in disease on the rule or law of " similars," so that we are enabled to initiate their use on our patients (strictly by the same rule) with well-grounded anticipations of success. Every single " homœopathic cure " is an additional *verification* of a new remedy, even if only the removal of *one* morbid symptom is effected.

It is in this way that our grand materia medica has grown from sixty-one remedies in 1821 to 1,010 in 1906. And I maintain this growth is by increment of *solid value*, more permanent than that of recent allopathic additions—unless, indeed, these are our own remedies rediscovered.

I may, perhaps, here be permitted to remind the Society that I have contributed to our materia medica fresh provings of *Rhus Venenata* (the variety known as "*diversiloba*"), which are recorded in Allen's tenth volume, and of a new plant, the OREODAPHNE *Californica* (misprinted *Oxeodaphne*) or California mountain laurel, also in the tenth (supplementary) volume. I shall be glad if members will correct this misprint on page 609 of vol. x. of " Allen's Materia Medica."

I propose in this paper, which I have had to divide into two parts because of its length, to discuss twelve remedies, some new, some old, and some forgotten. We do not, as the allopaths, lay aside our ancient weapons, although we use the latest invented. Though I am aware that this paper is being presented to an audience of homœopathic experts, I believe that it may be useful to bring before them that which may lie hidden in their memories, as well as that which may be altogether new.

The sphere of some of these selected remedies may be narrow, but I hold that if a drug can be proved to produce only one pathological effect on any part of the human organism, that drug becomes a remedy useful to the homœopath. This evening, out of ninety-one New, Old, and Forgotten Remedies, brought together by Dr. E. P. Anshutz in his recently-published book, I have selected six as worthy of our consideration, namely, *latrodectus*, *ceanothus*, *cratægus*, *iberis*, *stellaria*, and *thlaspi bursa-pastoris*.

Of these, as alone belonging to the animal kingdom, I will discuss first—

I.—LATRODECTUS MACTANS.

This is a poisonous spider found in countries so widely distant from one another as South Europe, the Southern States of the Union, and New Zealand. Already the order *Arachnida* has furnished to us the remedies—*Aranea diadema*, useful in ague; *Mygale* and *Tarentula*, effective in chorea; and *Theridien*, useful in true migraine and inframammary neuralgia.

The records of the poisonous effects of this particular spider cover new ground, and are of great interest to us, because they indicate a new remedy for that variety of *Angina pectoris* which is termed *Vaso-motoria*, first defined by Professor Nothnagel in 1867. The well-known Dr. Samuel A. Jones, of Ann Arbor, Michigan, analysed and commented on the five cases of latrodectus poisoning reported by Dr. G. W. Semple, of Virginia, in the *Virginia Medical Monthly* for 1875. The symptoms are not unlike those of serpent-bite, but there are differences.

I give an abstract of these five cases, three men and two women.

Case 1.—Mr. D., at 12.30 noon, on September 4, 1853, was bitten by a small black spider on the prepuce, while seated on the w.c. In half an hour nausea, followed by severe abdominal pains, and within an hour violent pains in the heart, extending to the axilla, and down the left arm to the fingers, with numbness of the hands and arm, and difficulty of breathing. An army surgeon had been called in urgently before Dr. S. arrived, and ordered cupping over the heart. The blood that came was thin and florid, and did not coagulate when emptied into a basin. Oozing of blood went on for some hours afterwards. Dr. S. found his pulse at 2.30 p.m. 130 and very feeble, his skin cold, and his countenance expressive of the anxiety he felt and expressed. There was no local pain, inflammation, or swelling at the spot where the bite had been received. Treatment by whisky and “sal volatile” and hot pediluvia was adopted, but Mr. D. did not rally until 2.30 on the 5th, twenty-six hours after the

bite, when he vomited black vomit copiously. A reaction set in, and he recovered after passing two black motions.

Case 2.—A man was bitten in the groin and almost immediately felt nausea, severe abdominal pain, and a sinking at the epigastrium; his pulse became quick and thready, and the skin very cold. This man soon recovered under ammonia and whisky, two quarts of the latter producing no symptoms of drunkenness. In fact, the same "toleration" of alcohol exists in these spider poisonings, as in snake-bites.

Case 3.—A lad, aged 18, was bitten on the back of the left hand. Violent pain began there, and in a short time extended up the whole arm to the shoulder, and thence to the præcordial region.

Case 4.—A coloured woman, aged 22, bitten on the right wrist, was found by Dr. S. *apparently moribund*; her skin cold; the pulse could not be felt in the left radial artery; the apnœa was extreme; the respiration only occasional, gasping; countenance full of anxiety; violent pain extended from the bite up the arm to the shoulder, and thence up the neck to the occiput on the right side; more violent pain in the præcordia, extending thence to the left shoulder and axilla, and down the arm to the ends of the fingers, the arm feeling partially paralysed. This patient was saved from death by the intravenous injection of thirteen minims of undiluted aqua ammonia.

Case 5.—A healthy girl, aged 13, was bitten on the right wrist. In half an hour a painful sensation began to be felt at the spot, which quickly extended up the arm to the shoulder, and in an hour along the neck to the occiput; "pain in the præcordial region, with apnœa coming on. I was sent for. When I arrived she was screaming with pain, and exclaiming she would lose her breath and die. The pulse had become thready and the surface cold."

Dr. Jones has analysed and classified the toxic symptoms produced by these *latrodectus* in these five sufferers, thus:—

In four out of the five cases these symptoms occurred: (1) præcordial pain; (2) pulse feeble and thready; (3) coldness of the whole surface of the skin. In three cases there were: (1) apnœa; (2) pain up the arm of the side affected to the shoulder, thence to the præcordial region; thence in two cases to the occiput and nucha; (3) sense of impending

dissolution, with the corresponding anxiety and dread expressed by the countenance. In two cases the primary symptoms produced were (*a*) nausea, and (*b*) severe abdominal pain, the insect-bites having been inflicted upon the penis and the groin respectively, thus quickly affecting the splanchnic nerves through the solar plexus.

In two cases the *left* arm was partly paralysed, even when, as in Case 4, the patient had been bitten on the right wrist.

The isolated symptoms recorded were: black vomit and black stools (Case 1): sinking at the epigastrium (Case 2): respiration only occasional, and gasping (Case 4).

Cognate with the pathogenetic effects of *Latrodectus mactans* are those of *Latrodectus katipo* of New Zealand, of which I here exhibit three fine specimens, very rare and difficult to obtain, as the Maoris dread them. The bite of this latrodectus speedily inflames the skin, causes visible lymphangitis and nervous twitchings, reminding us of Tarentula.

In one case of katipo-bite on the foot, a scarlet papular eruption, burning like fire, came out on the leg. Another sufferer, a man, wasted away for three months, and took six months to recover. A man consulted me in Auckland, New Zealand, for a chronic inflammation of the septum narium, which he declared was solely caused by a katipo-bite on the face, inflicted eighteen months before. Fatal cases are rare. The only one recorded in "Clarke's Materia Medica" (s.v. *Latrodectus*) is that of a girl who died six weeks after a bite on the abdomen.

In the *Auckland Star* of September 27, 1901, is noted the death of George Twidle, jun., aged 47, who had been bitten by the spider while putting on his coat, which had been lying on the ground. This was on September 16. "In spite of all that medical aid could do, deceased died on the following Saturday, September 21, after severe suffering." No further particulars than these are given.

We are not able to ascertain whether angina symptoms are present or absent in poisoning by *L. katipo*.

Copland's definition of angina pectoris is, "Acute con-

stricting pain at the lower part of the sternum, inclining to the left side, and extending to the arm, accompanied with great anxiety, difficulty of breathing, tendency to syncope, and feeling of approaching dissolution."

The exact resemblance to angina pectoris of *L. mactans* poisoning is evident. The symptoms of the poison bite even follow the order of those of "*vaso-motor angina pectoris*." Vaso-motor angina is caused by a sudden *spasm of the peripheral systemic arterioles*—in the cases I am discussing, caused by the toxin of the spider—a spasm which resists, by high tension in the arteries, the blood-pressure normally exerted by the ventricles in systole. As soon as the coronary arteries are reached by this spasm, intense pain and the temporary impediment, or half-suspension of the ventricular contraction, takes places. "*The pain itself*," writes Osler, "*undoubtedly is in the cardiac plexus, and radiates to adjacent nerves*." Hence the immediate relief given in an attack by the inhalation of amyl-nitrite, which instantaneously *relaxes* the arterioles, and allows the ventricles to pump out the blood-stream. Of course the true angina that is sometimes fatal occurs in persons whose coronary arteries have been for some time in a state of degeneration. In this class of angina cases I do not advise latrodectus, but rather glonoin, hydrocyanic acid, or spigelia.

Dr. Linnell, in the *North American Journal* for December, 1890, reports two cases of the vaso-motor form of angina greatly relieved by latrodectus 3.

I think we are warranted in using this remedy in vaso-motor angina pectoris.

The whole spider immersed, alive, in alcohol, is the form in which the matrix tincture is prepared.

II.—CEANOTHUS AMERICANUS.

This remedy has in practice amply justified Dr. Burnett's recommendation in diseases of the spleen, in 1887. It belongs to the natural order Rhamnaceæ, or the Buckthorns. It is indigenous to the Northern States, and is there known as New Jersey Tea, Red Root, and Wild Snowball. The

tincture is prepared by maceration from the fresh leaves pounded into a pulp.

In the third edition of his "New Remedies," Dr. E. M. Hale first introduced ceanothus, citing testimony from old school and eclectic sources as to its value in inflammation and enlargement of the spleen, and adding the statement which suggested to Burnett its homœopathicity to these morbid conditions, namely, that "in chronic cases, when the spleen is no longer tender, under the use of ceanothus tincture it soon *becomes painful and tender* [Hahnemann's medicinal aggravation], and *then sinks rapidly to its normal size.*"

Dr. Burnett began to use ceanothus about the year 1874; has written several interesting papers upon it, both in the *Homœopthic World* and in the *Homœopathic Review*, and summed up his experience of it in his booklet, "The Spleen and its Diseases," published in 1888.

His contributions to the *pathogenetic* effects on those to whom it had been given are these :—

(1) Ceanothus frequently relaxes the bowels, even to the extent of diarrhœa.

(2) An intelligent young lady, aged 26, had been taking ceanothus, four drops thrice a day, with great benefit, when "one day I felt great nervous excitement, with chilliness, loss of appetite, and such a shaky condition of the nerves that I could scarcely hold knife and fork at dinner. I shivered with cold chills down the back." She discontinued the medicine, and all these symptoms ceased. Resuming ceanothus they reappeared. Some diarrhœa ensued.

(3) *The menses subsequently came on profusely, ten days too early*, an unprecedented event in her experience.

(4) Dr. Fabuestock, of the United States, proved ceanothus upon himself, and found that it caused a sticking pain in the spleen, followed by enlargement of that organ, worse on motion, and rendering him unable to lie upon his left side.

(5) Following these symptoms came similar symptoms in the liver

(6) The urine was greenish, frothy, alkaline; specific gravity 1030, and showed the presence of bile, with traces of sugar.

Ceanothus not only relieves deep-seated pain in the region of the spleen without affecting any other part of the body as a rule, but it actually reduces a chronically enlarged spleen, and seems to renovate a constitution which has broken down and has contracted pseudo-heart disease, chronic cough, leucorrhœa, dyspepsia, and attacks of dyspnœa. I now condense the reports of a few typical cases of cure :—

Case 1 (Burnett).—Lady, suffering from acute splenitis. The symptoms were violent vomiting, cough with expectoration, pain all up the left side, profuse sweats and fever. For three weeks the patient was treated as for pleuro-pneumonia, the spleen not having been percussed by the orthodox remedies, but without effect. After a careful examination, the spleen being found large and tender, ceanothus 1x cured in ten days.

Case 2 (Burnett).—A servant, aged 55, suffering from cardiac palpitation and violent attacks of dyspnœa, was found to have both spleen and liver greatly enlarged. She had been ill from ague in Northamptonshire thirty years before this (October, 1879). Splenic dulness extended to left mamma, and she could not bear even the pressure of her clothes. Five weeks of ceanothus 1x relieved all her symptoms, even the left side pain which had lasted twenty-five years. Drinking anything cold brought on the dyspnœa. Ceanothus 1 for two months more completed the cure.

Case 3 (Burnett).—A lady, aged 55, complained of rigors at frequent intervals; distressing pain in the left side; and profuse thick yellow leucorrhœa, which had lasted for twenty years and resisted the best allopathic treatment obtainable in Chester. Ceanothus 1 entirely cured the splenic pain and also the leucorrhœa in one month, but did not quite remove the "cold feelings," though these were very much diminished.

Case 4 (Anon.).—From *The Clinique*, January, 1901, is quoted the following case in Vol. xlv. of the M. H. R. Mr. V., aged 31, came August 23, 1900, stating that he had contracted malarial fever eight months previously. Quinine controlled the ague, but continual pain in the left side and back remained. He is tired and exhausted all the time, losing flesh, perspiring easily, has a cough which increases the left side pain, this pain being worse in wet and in cold weather. Without distinct periodic

rigors, there is still frequently a chilliness down the back, and slight feverishness at irregular intervals.

The spleen was found much enlarged and tender to pressure. *Ceanothus* ϕ , three drops every three hours, improved him greatly in a week; in three weeks all enlargement and tenderness of the spleen had disappeared, and the patient was well.

It seems to me that we might profitably use *ceanothus* in cases of leucæmia in young anæmic girls, who, as we know, often complain of *pain in the left side, through from the back of the waist to the front*, probably splenic, and often due to tightly-laced stays. In dispensary practice one is too often inclined to put these hastily down as ovarian. There should be, but I cannot detect it, some peculiar complexion of the skin which indicates enlarged, inflamed, or diseased spleen. Between the splenic, the slightly jaundiced, the anæmic, and the cancerous cutaneous tints, it is difficult to distinguish.

Perhaps some colleague will throw light in the discussion upon this point of external diagnosis. In the case of chronic recurrent splenic hæmorrhage, which I reported in my "Common-Sense Homœopathy," 2nd Edition, p. 62, I found *ceanothus* ϕ of the greatest possible value. Miss A. D. B. lives close to my house, and I have kept her under observation. She has had no hæmorrhage whatever since 1897, and is well in every respect, in fact, more stout, robust and active than before her long illness (1888 to 1897).

We certainly owe to Burnett the knowledge of how to apply *ceanothus* in diseases of the spleen; and even in deep-seated pain in the left hypochondrium *not* dependent upon splenic enlargement.

III.—CRATÆGUS OXYACANTHA

of the Natural Order Rosaceæ, sub-order Pomeæ. This is the Common English Hawthorn or Whitethorn. A tincture is made from the fresh berries, pounded to a pulp, and macerated in twice their weight of S. V. R. It is strange that we find in this ancient and hardy plant, as characteristically English as the daisy or the crab-apple, a heart remedy as efficient as the delicate tropical *Cactus grandiflorus* or Night-blooming *Cereus* of Mexico and the West Indies.

It was a new era of relief for heart sufferers when Dr. Rocco Rubini first introduced this latter (Cactus), which had been imported into Naples, to the profession, by his pamphlet written in 1864, and translated by Dr. Dudgeon in vol. xxi. of the *British Journal of Homœopathy*.

The introduction of *the new Cactus*, as I may call it, is due to the revelation of a secret cure used by Dr. Green, of Ennis, Ireland, by his widow, after his death in 1893. He had earned a national reputation for "curing heart disease," with or without dropsy, so extensive that his fame attracted patients from all parts of the United Kingdom.

Dr. M. C. Jennings reported his success with cratægus in forty-three cases of heart disease in the *New York Medical Journal*, October, 1896. Dr. Jennings is an old-school physician, so that his cases are somewhat "mixed" as to treatment, but as early experience of this new drug is of value I give two of his cases.

Case 1 was that of Mr. B., aged 73. I found him gasping for breath, with a pulse of 158, very feeble; he had great œdema of abdomen and legs. I gave him 15 drops of cratægus in water. In fifteen minutes the pulse beat was reduced to 126, and was stronger, and the breathing less laboured. In twenty-five minutes the pulse was 110, and still stronger, and the breathing much easier. A second dose of ten drops was given. An examination of the heart revealed mitral regurgitation from valvular deficiency, with great enlargement. In one hour from the first dose Mr. B. was for the first time in ten days able to lie horizontally in bed. For the œdema I prescribed *hyd. cum cretâ*, *squill* and *digitalis*, but also he received ten drops four times a day of the cratægus tincture. In three months he recovered, and said he felt as well as any man of his age in Chicago. He still takes cratægus whenever he feels shortness of breath, or pain in his heart, with quick and perfect relief. His father and a brother died of heart disease.

Case 2 was that of a young woman whom I was informed was already dead when I entered the house. I went in and found that she was not quite dead, though apparently so. Putting amyl nitrite to her nostrils and applying artificial respiration, I had the gratification of seeing her eyes open and consciousness return. In half an hour she was able to talk and describe her feelings. An examination revealed a painfully anæmic condition

of the patient, but no discoverable lesion of the heart, only functional weakness. Her pulse had been restored by the hypodermic injection of ten minims of amyl nitrite.

It was a case of heart failure, following on a long exhausting illness—chronic dysentery and dyspepsia. She received ten drop doses of cratægus thrice daily after meals for one month, after that only occasionally, and made a good recovery. In ten weeks she was in a perfect state of health.

Case 3 is that of Dr. Jos. Clements, who thus relates his experience (condensed by me) in the *Kansas City Medical Journal*, 1898.

“About twelve years ago I was suddenly seized with terrible pain in the left breast, extending over the entire cardiac area and down the left arm as far as the wrist. I pressed my hands over my heart and seemed unable to move. My lips blanched and my eyes rolled in agony; the most fearful sense of impending calamity oppressed me; I expected death. The attack lasted a short time and then subsided, leaving me weak and excited. In two years, and again a year later, I had attacks. I took nitro-glycerine tablets and cactus pills without benefit. About fifteen months ago I was feeling very badly, having had several attacks within a few weeks. My pulse was at times very rapid and weak, also irregular and intermittent.

Hearing about cratægus I got some, and tried it, beginning with six drops, increasing to ten, before meals and at bed-time. In twenty-four hours my pulse showed marked improvement; in two or three weeks it became regular and strong. Palpitation and dyspnœa left me, I began to walk up and down hills without difficulty, and felt a general sense of security and well-being. Yet I had several slight attacks of this “angina,” and one rather hard seizure, which was promptly relieved by ten drops of cratægus. I consider it the most useful discovery of the 19th century.”

Case 4 is reported by Dr. Halbert in the *Medical Era*, 1901. A youth, aged 20, suffered from congenital(?) valvular heart disease, with dilatation brought on by cycling up-hill, and from imperfect compensatory hypertrophy. Dr. H. found him in a most critical condition in the summer of 1900. “The præcordium was bulging; the apex beat was down to the outer border of the sixth rib; the right heart was greatly enlarged; epigastric pulsation was pronounced; the dyspnœa was terrible to behold, both aortic and mitral regurgitation were extreme, and cyanosis was evident.

Strychnia, digitalis, and every remedy and adjuvant I could think of were used with only temporary effect. After several days I gave cratægus, five drops four times a day, gradually increased to eight drops. At the end of a fortnight the improvement was quite pronounced. The cardiac muscle was steadily strengthening, and affording the needed compensatory action. An unfortunate attack of pneumonia supervened, through which we nearly lost him, but he survived, and again cratægus was given, *and persevered in for some weeks*. A few months after his return from the country I met him in town, and he said he was "all right and attending to business."

Dr. Halbert records two other cases of aortic and of mitral regurgitation respectively, where cratægus restored the heart to a workable and comfortable condition.

Case 5 is interesting as that of an esteemed colleague, Dr. Bernard Arnulphy, of Nice, known to some of us, who records the effects of cratægus on himself in a paper to the *Revue Homœopathique Française* for December, 1900, which compares the action of naja and of cratægus in diseases of the heart.

He writes: "I had an opportunity, at Chicago, of watching the action of cratægus on my own person during an attack of influenza, which had affected the heart to such an extent that my pulse was imperceptible, and I could not rise from a horizontal posture without being threatened with syncope. Its action here was on an acute myocarditis, well marked but quite painless, and unaccompanied by cough. I took cratægus for fifteen days, at the end of which time I could get up and attend to business. That the cure was thorough is proved by the fact that I have since been able to climb Alpine summits of 3,000 metres without trouble.

Cratægus is as yet unproved, except that Dr. T. C. Duncan, of Chicago, reports that it caused in him "a flurried feeling due to the rapid action of the stimulated heart," and in a lady proves, first "an unusual rush of blood to the head with confused feeling," followed by "a feeling of quiet and calmness mentally."

Dr. Arnulphy compares, in an interesting and concise way, naja with cratægus. "Whereas the latter does great service in every form of myocarditis, and exhibits an undeniably tonic action, quiet, moderate, and non-cumu-

lative, on the muscular fibres of the heart, equally suiting both aortic and mitral cases, *naja* is especially curative of acute and of chronic endocarditis."

And he adds, "the insomnia of aortic sufferers is generally helped by *cratægus*."

I regret that I have no clinical experience of my own with this new remedy as yet.

It is well to note that some patients experience nausea if they take the above material doses of *cratægus* before a meal. It is not a suitable remedy for fatty degeneration of the heart. It is safer but slower than *digitalis* in "toning up" a weak heart. Compare *cratægus* with *cactus*, *naja*, *phaseolus*, and *amygdala amara*.

IV.—*IBERIS AMARA*,

of the Natural Order *Cruciferae*, is the "Bitter Candy-tuft," found in England and other parts of Europe, and named from Spain (Latin, *Iberia*) which was supposed to have been its original habitat.

The seeds are used in making the tincture.

The pathogenesis of *Iberis* begins with the provings by three of Dr. E. M. Hale's students, who reported 150 symptoms, eighteen of which related to the heart. They experienced "dull or stitching pains in the heart, with palpitation and breathlessness on the slightest exertion; pains down the left arm, tingling and numbness, commencing in the fingers of the left hand and gradually extending up the arm; rapid, irregular, and sometimes intermittent pulse; dyspnoea with stabbing pains through the heart. One peculiar symptom which may possibly be a "key-note": "*On turning, in left side a sharp sticking pain is felt, as if a needle were cross-wise in the ventricles and pricked at each contraction.*"—Symptom 93 in Allen. The pulse was raised to 100 per minute as a maximum in two provers, but after most of the doses taken the pulse rose to 85 or 90; its quality varied, once being described as "accelerated, irregular and jerking, with a peculiar thrill under the finger." Again, as "100 per minute, with peculiar double beats which seemed

to run into each other, full, and easily compressed." There were produced important concomitant symptoms in the two male and one female students—vertigo, nausea, throbbing pain through temples, choking in the throat, excessive nervousness and frightened feeling, &c.

Symptoms worse on lying down and on lying on left side, while at the same time, tremblings, weakness and nervousness cause desire to lie down. One male prover passed two thin, clay-coloured stools, resembling those of digitalis. After each dose the ventricular contractions were powerfully increased for an hour or more in all three provers.

Dr. E. A. Gatchbell's experiments on frogs in 1877 confirm this effect of iberis. As far back as 1847, Dr. Sylvester (allopath) related to the Provincial Medical Association a series of cases in which he and a colleague had given iberis in doses of one to three grains with excellent results, especially in cardiac hypertrophy, where "it does not diminish the heart's action, like digitalis, but controls its violence and sharp action, softening the pulse." The new drug "occasionally induced giddiness, sickness, or diarrhœa, but these subsided on discontinuing it."

The personal experience of my friend and neighbour, Dr. Proctor, of Birkenhead (who first called my attention to iberis), is valuable, and I am pleased to see it incorporated in his *Materia Medica* by Dr. Clarke, because Dr. Proctor's observations are accurate and matter-of-fact—therefore trustworthy.

Case 1.—Dr. P. Proctor, a blonde, aged about 50, after influenza in 1890 suffered from cardiac weakness for two years. Tobacco and all stimulants, except port wine, aggravated his symptoms so much that they had to be given up. All the ordinary heart remedies were tried, but without relief. Iberis amara was taken, and in ten days cured him.

Case 2.—Dr. Chakravanti, of India, reports the case of a railway clerk, aged 30, suffering from rheumatic endocarditis, and consecutive pericarditis with slight effusion, which, after the failure of cactus 3 and of arsen. 30, iberis 30 cured completely in the course of ten days (*Homœopathic World*, June, 1905).

I have given iberis 1x occasionally to patients suffering from functional palpitation attacks, and always with benefit. It deserves to be more employed than it has been ; I find very few cases recorded, and I hope my colleagues will use it more freely. Dr. Clarke thinks that the symptom, "*conscious of the heart's action*," may be a keynote for iberis. I prefer the "pure" pathogenetic symptom, No. 93 of Allen quoted above, just as we have in the courageous provings by Dr. and Mrs. Rubini of cactus, the *characteristic* symptom "*sense of constriction round the chest (or heart region) of an iron band*," or, "*as if the heart was grasped by a hand*."

As cratægus needs to be proved schematically, and iberis needs reproving, I commend both to the notice of the Proving Committee of the British Homœopathic Association. I will now proceed to

V. STELLARIA MEDIA,

the common chickweed, of the Natural Order *Caryophyllaceæ*, whose provings by Kopp of New South Wales, in 1893, and by Dr. A. E. Ibershoff's Class in the University of Michigan, in February and March, 1904, display a marked resemblance to the articular, and sometimes to the muscular, symptoms of acute and of subacute rheumatism, also to those of hepatic congestion and enlargement. Hence the interest to homœopaths of this smallest of all phanerogamous plants, hitherto considered only fit for small birds' food. Chickweed, though tiny, is a hardy plant, growing in shady places all over the world, even in Siberia ; and it has successfully maintained itself in the "struggle for existence" since the earliest times.

Caged birds cannot maintain their health without it ; it is even a tonic, as old Turner (1551) puts it (translated by Gerarde, 1597), "Little birds in cages are refreshed with chickweed when they loath their meate." Another mediæval herbalist writes : "The water of chickweed is given to children for their fits, and its juice is used for their gripes."

Doubtless the abundance of potassium-salts in the plant gives it some anti-scorbutic properties, and may give us an

indication of its chemical as well as its dynamic action in rheumatism as a remedy.

Now the question is, to define the sphere of stellaria; for we have already many well-tested remedies both for rheumatism in all its forms, and for hepatic congestion, or rather inaction, for the provings scarcely reached the point of what I understand by "congestion." I will now condense the summary of Dr. Ibershoff's proving and add to it such symptoms as Mr. Kopp experienced on himself, in so far as they differ from the former series, distinguishing these by "K." The provings directed and superintended by Dr. Ibershoff were made upon twelve male and four female students of the "Homœopathic Department of the University of Michigan," beginning on February 17, 1904, and lasting for four weeks.

The scheme was projected in the very best way to obtain the pure effects of the drug. The whole plant in bloom was macerated in twice its weight of alcohol, and different doses were given to each of the sixteen provers, ranging from one drachm of the ϕ tinct. up to four doses of the 30x. For the details I refer you to the *Monthly Homœopathic Review* for July, 1904.

The definite symptomatology of stellaria presents the following facts of special interest:—

General.—Lassitude, constant sleepiness, awaking feeling tired and dizzy. Tired, sore, strained feeling as from over-exertion.

Head.—Dull, frontal headache, worse on left side, increased in the morning by motion, by warmth, passing off toward evening. Violent headache all over cranium.

Vertigo.—Dull supra-orbital headache, worse over the right eye, with faintness. Headache increased from sudden jar or motion. Stiffness and soreness of neck-muscles (2 provers). Rheumatic-like pains darting through the whole head, worse on right side, with the parts sore to touch (K). Ditto in the left half of forehead, over the [left] eye sore to the touch (K).

Eyes.—Smarting and burning, dry feeling, feeling as if the eyes protruded, eyelids feel swollen, and the eyes strained.

Mouth.—Dry, thirst for small drinks at frequent intervals.

Stomach.—Bad taste in mouth on awaking. Nausea, almost constant. Loss of appetite, flatulence, stomach sensitive to pressure.

Chest.—Severe left-side pains. Intermittent stitching pains, especially on left side.

Back.—Sharp pains in small of back over kidneys, coming on suddenly; they reach their maximum slowly and stop suddenly. Sharp, stitching pains in left side of back, in the region of the spleen, severe and intermittent. Rheumatic-like pains across the small of the back, increasing on bending or stooping (K). Stiffness with soreness in lumbar region (K).

Abdomen.—Flatulent distension with colic. Liver engorged, swollen, with stitching pains, soreness and sensitiveness to pressure, increased by lying on right side. Pain in left hypochondrium. Pain in epigastrium.

Stool.—Constipation. Violent pain in rectum after stool.

Extremities.—Rheumatoid pains in different parts of body. Sciatic pains. Shooting (rheumatic-like, K) in ankle, hip and knee, below knee-cap (K). Dull ache in left arm and shoulder, increased by rest and warmth. Rheumatic pain in right shoulder, increased by lying on right side. Sharp, shooting pain in left knee, extending into ankle joint. Sharp, darting rheumatic pains in left knee, extending above along the thigh (K). Rheumatic pains darting down right arm and middle and index fingers of left hand (K). Rheumatic pains in calves of the legs, which are sensitive to touch (K). Hands warm, feet cold.

Modalities.—*Worse* in the morning, from warmth, tobacco, and at rest. *Better* in the evening, from motion, from fresh cold air; pressure (headache), eating. There are exceptions to these conditions, however.

In none of the sixteen provers were there any abnormal symptoms of the generative organs, nor were there changes caused in the blood or in the urine, except in two cases where the alterations noted were due to other causes.

One prover who had been constipated previously, noted an aggravation of this during the first few days of the

proving, followed by amelioration, going on to actual diarrhœa.

The "rheumatoid" pains, as Dr. Ibershoff styles them, were in all provers shifting and intermittent. In this, along with their relief from motion, and aggravation from warmth, we perceive a resemblance to *pulsatilla*, but the head, stomach, and liver and bowel symptoms, point to congestion or sluggishness of the functions, and with the morning aggravation, &c., remind us of *nux vomica*.

Perhaps the old vernacular name for this plant, "*stitch-wort*," indicates its characteristic, for "*stitching pains*" occur frequently in the provings. If we add to this the *shifting* character of the "rheumatic-like" pains, we obtain as nearly as may be in our present limited knowledge of the plant a "keynote" for *stellaria media*.

Dr. Ibershoff believes it "to have a small but well-defined field of action."

The clinical use of *stellaria* in homœopathy began with the report by the late Rev. F. H. Brett of the cure of Mrs. Brett's gout (in the fingers), also of his own gout (in the feet), in the *Homœopathic World* of June, 1893. Mr. F. W. Kopp then proved the plant, and has been very industrious in reporting cases treated with it in New South Wales.

Cases 1 and 2.—Rev. F. H. B. and Mrs. B. were treated and cured by the *local* application of *stellaria* ϕ tincture of uncertain strength. None was taken as a medicine.

Case 3.—A man suffering from rheumatism, in whom the pains shifted about, now in the ankles, then in the knees, then in arm, wrist or fingers.

The patient was cured. Mr. R. H. Bellairs reports the case in the *Homœopathic World* for January, 1896, but I cannot cite it in full, not having that volume.

Case 4.—A man, aged 27, who had previously suffered from rheumatism, came to Mr. Kopp to consult him about his inflamed left knee joint, which was so painful as to prevent him from walking. Mr. Kopp pronounced it to be rheumatic synovitis. *Stellaria media* 2x, three drops every two hours, was ordered, and the knee was wrapped in bandages saturated with a lotion of the ϕ tincture—sixty drops to six ozs. of water. Relief was obtained in a few hours, and complete recovery in a week.

(*Homœopathic World*, July, 1902.) I do not think bry. or ledum would have improved upon this result.

Case 5.—A woman, aged 36, had rheumatic sciatica in the left leg, from the hip to the foot. The pain was not so severe in the daytime, but at night, as soon as she got warm in bed, the pains were excruciating, darting from the hip down the thigh to the knee, and thence to the foot. *Rhus tox.* 1x was given internally by Mr. Kopp, and the lotion of *Rhus. φ* tincture, but without relief. Then *stellaria* 2x was prescribed in distilled water, in doses of three drops, every three hours, and a liniment was rubbed into the painful parts morning and night, consisting of *stellaria φ*, one part in ten parts of methylated spirit. The patient quickly got well—in a week, in fact, and after some months, up to the date of the writing down the case, there had been no return. (*Homœopathic World*, July, 1905.)

I have just now an obstinate case of “flying rheumatism,” chiefly affecting shoulders, lumbar muscles and hips, in an otherwise healthy, robust man of 56, who lives most of his time in the open air in Cumberland, and has contracted the disease from the constant exposure to cold and damp. After the failure of *rhus*, sulphur and puls. I found *stellaria φ* succeed in *relieving*, but *not curing* them. I was led to choose it because of the shifting of the pains. He travels so constantly that I cannot get any local application used, so possibly the want of *local stellaria* lotion, or liniment, may have lessened its curative effect. After fourteen days I had recourse to *rhus* again, under which he is slowly getting better.

I do not class this case as a *stellaria* cure, but record it as my only personal experience, thus far. *Stellaria* has a future before it, and I recommend its trial by colleagues.

The last medicine I shall discuss this evening is

VI.—THLASPI (OR CAPSELLA) BURSA-PASTORIS,

the common “Shepherd’s Purse,” or St. James’s wort, of the Natural Order *Cruciferae*. Three parts of the fresh plant, in flower, are macerated in two parts of S.V.R. to make the *φ* tincture. Also an effective fluid extract is made by chemists. Analysis proves that this plant contains tannic acid, 6 per cent. of a soft resin (alkaloid), and a sulphuretted

volatile oil identical with that of mustard (*Sinapis nigra*), from which the white crystalline alkaloid, theosinamin, is derived by distillation with ammonia.

Thlaspi, which is *thlaspis* (θλάσπις) in correct Greek, is first mentioned by Dioscorides of the first century, A.D., as an emmenagogue, abortive, anti-hæmorrhagic and a remedy for sciatica. The seeds of this plant, in his day, were crushed and used for medicine, hence the name, θλάσπις, from the verb θλάω, "I crush."

The long and clumsy name might be shortened to the modern botanical appellation of "*Capsella*." This late-Latin diminutive of "*capsa*," a box, translates its vernacular name, "shepherd's purse," derived from the flattened, hollow, pouch-like seed vessels hanging at the end of each stem. In botanical lists its full name is *Capsella bursa-pastoris*.

To herbalists and to a few physicians this plant's properties have been known in mediæval times. It has not been *systematically* proved by the Hahnemannian method, although Fincke reports a trial of it in the *Trans. of the Hahnemannian Association* in 1895 and J. C. Fahnestock, in 1896, obtained the following definite results:—

- (1) Puffy or swollen eyelids.
- (2) Great increase in the quantity of urine passed.
- (3) Copious excretion of uric acid in the form of sand.

In the *Monthly Homœopathic Review* for October, 1888, our valued and lamented colleague, Dr. Dudgeon, wrote an able article upon *thlaspis*, calling attention to its therapeutic value, and giving cases cured by it, which I shall quote later.

Lejeune, in 1822, used it successfully in hæmophysis. Rademacher, who was born in 1772, and died in 1850, had a high opinion of it. I shall give two of his cases.

Both Dudgeon and Burnett, who notices *thlaspis* in his "Greater Diseases of the Liver" (1891), took up the plant from Rademacher's use of it.

From his clinical experience of *thlaspis* Dudgeon concludes that "this medicine deserves a thorough and complete proving. It is evidently a powerful anti-hæmorrhagic,

and its influence on the urinary organs, more particularly in bringing away and in curing excess of uric acid in the urine, is very remarkable."

From the homœopathic journals accessible, I have compiled and tabulated nineteen cases, reported (sometimes imperfectly) by Rademacher, Kinil, Jousset, Dudgeon, Raffinesque, Burnett, Deschere, Waldo H. Stone, R. M. Lewis, A. Midgley Cash, J. P. Harper, Clarke, and Millie J. Chapman. I hope the members present will add to the list.

Cases cured by Thlaspi Bursa-pastoris.

Case 1, female, age not stated, reported by Rademacher.—A poor woman who had suffered from uric acid sand ten years before, sent again for Dr. R., who found ascites and œdema of legs, and hæmaturia. Thirty drops of the tincture five times a day brought away great quantities of sand, increased the urine, completely removed the dropsy, and restored the patient to health.

Case 2, female, age 30, reported by Rademacher.—Patient came to me for a complication of diseases, no sand in the urine. Thlaspi tried, produced a quantity of it, and this continued until all her morbid symptoms disappeared.

Case 3, female, age not stated, reported by Kinil.—Three weeks after partus patient had "strangury" and pain in the urethra, the urine, which was turbid, and deposited deep red sediment, dribbled away, drop by drop. Thlaspi ϕ , thirty drops, five times daily, relieved all symptoms, and in eight days the urine was clear and without sediment.

Case 4, female, age not stated, reported by Jousset.—Obstinate hæmorrhage after miscarriage, unchecked by secale, crocus, perchloride of iron, tampons, &c., arrested by two doses of twenty drops of the tincture.

Case 5, female, age not stated, reported by Dudgeon.—A young French widow, after recovery from severe jaundice, had a brownish grumous blood-like discharge after the catamenia for two months, with abdominal pains. Cervix uteri soft and swollen, but *not ulcerated*. The usual remedies failed to check this, nor did cocc. sulph. or conium succeed. Returning to Paris, she consulted Dr. Raffinesque, who discovered irritation of the

right ovary, and post-menstrual congestion of the liver. He gave bell., nux, sabina, creos., ferrum, &c., in the inter-catamenial periods, but no remedy checked or altered the "metrorrhagia," as Dudgeon terms it, until thlaspi 6, then ϕ , and then 6 again, which cured in a month. This interesting case is detailed by Rafinesque in vol. xxxii., pp. 370-4, of the *British Journal of Homœopathy*.

Case 6, female, aged 76, reported by Dudgeon.—An old lady had rheumatic muscular pains in various parts, and constant profuse sweats, day and night, and passed uric acid sand with every micturition. Sometimes uric acid calculi, causing much pain in the ureter. After cessation of the sweats and pains, which lasted seven weeks, the sand continued to be passed. Puls., picric acid, lycop., &c., failed, but under thlaspi 1 the sand disappeared altogether.

Case 7, male, aged 57, reported by Dudgeon.—A gentleman with dyspepsia, occasionally passed large discharges of coarse uric acid, coming away in masses the size of a big pin's head but without pain. Thlaspi 1 soon stopped this, and for a year afterwards always acted promptly upon any return of the symptom.

Case 8, female, aged 79, reported by Dudgeon.—A lady, nearly 80, was suffering from a calculus (uric acid) in the left ureter, urine very scanty and *not showing sand*. Several remedies failed, and even the copious drinking of *aq. destill.*, which powerfully disintegrates uric acid sometimes, had no effect. Thlaspi 1 caused a great discharge of sand, with speedy relief to all the symptoms.

Case 9, female, age 32, reported by J. P. Harper.—For nineteen months Mrs. — had suffered from chronic diarrhœa and latterly from dysentery, when she came to me, January 12, 1888. Daily in the morning she passes, after the last of the dry dark stool, a teacupful or less of yellow muco-purulent discharge. Also blood was voided with some stools. She is pale, looks puffy, and has slight œdema of feet and ankles. After the most careful dieting and strictly homœopathic medication for two years, Dr. H. failed to give more than temporary relief, until on February 20, 1890, he gave thlaspi ϕ , η i. quater die, which in two days stopped the blood; in three weeks the muco-pus; and in five weeks *cured* permanently a dysentery which had lasted more than three years.

Case 10, female, aged 46, reported by J. P. Harper.—Miss A., suffering from a fibroid tumour of the uterus, had menorrhagia every fortnight, in which calc. carb. and sabina failed. She became very pale and anæmic. Given on October 15, 1888, thlaspis ϕ , four times a day, which arrested the bleeding at once, and for many months there was no return, although the tumour, reduced in size, remained.

Case 11, female, aged 48, reported by J. P. Harper.—Mrs. C., very anæmic and exhausted from constant uterine hæmorrhage, caused by a polypus, was very greatly improved by thlaspis ϕ . It controlled and diminished the bleeding more promptly and for a longer time than even ergot, of which she had taken quantities. From March, 1889, to June, 1890, thlaspis gave her this benefit, but did not affect the growth of the polypus, which at last was removed by operation.

Case 12, male, reported by Deschere.—A man who "had an obstinate hæmoptysis of unaccountable origin," was cured by thlaspis ϕ in doses of ten to thirty drops.

Case 13, male, aged 63, reported by A. M. Cash.—Patient has been ill a long time with his kidneys. He has hæmaturia increased by the slightest movement, and passes also pus and large uric acid crystals in his urine. The sound reveals no calculus. Arnica, millefol., hamam., tereb., all failed, but two-drop doses of thlaspis ϕ much diminished the blood in five days and eventually stopped it. Three months later he reported that there had only been one slight return, promptly arrested by thlaspis.

Case 14, female, age not stated, reported by Burnett.—A lady suffered from uterine troubles, and afterwards from gall stones. The latter condition was removed by thlaspis (contrast Dr. Dudgeon's case, No. 5). Burnett thinks thlaspis affects the *uterus* in the same way as chelidonium influences the *liver*.

Case 15, female, age not stated, reported by Waldo Stone.—A lady, after a confinement, had suppression of urine, which caused eclampsia. Thlaspis was given (dose and dilution not stated) with the effect of causing 115 ozs. of urine to be passed in twenty hours, and thus saving her life.

Case 16, female, aged 34, reported by R. M. Lewis.—Mrs. — (mother of 4 healthy children), whose confinements had been normal, began to develop ascites six months before con-

sulting Dr. Lewis. The whole body and limbs were anasarcaous, the urine scanty, only 20 ozs. in twenty-four hours; pulse 140, respiration 53. The urine deposited brick-dust sediment, and smelled like that of a horse. After the failure of arsen. and of apis, thlaspi ϕ , every three hours, began an immediate improvement, which went on to a complete cure within six weeks.

Case 17, female, age not stated, reported by Millie Chapman.—A lady had long suffered from disease of the bladder, aggravated by local treatment, and from persistent “rheumatic” pains. Thlaspi 1, and, later, the ϕ tinct. in five-drop doses, expelled a quantity of uric acid sand, and cured all the morbid symptoms.

Case 18, female, reported by M. Chapman.—Another case of similar bladder irritation, with marked evidences of gout also, was promptly relieved by thlaspi.

Case 19, female, age not stated, reported by J. H. Clarke.—A lady who had been curetted several times with but little success, to arrest uterine hæmorrhage, consulted Dr. Clarke to save herself from a further operation of the kind which was deemed essential to her recovery. Thlaspi 1x stopped the hæmorrhage and restored the normal menses. She recovered her strength, and there has been no further return of the trouble. Dr. Millie J. Chapman also confirms this efficacy of thlaspi, in place of curetting.

These nineteen cases may be thus summarised :—

Uterine hæmorrhage, idiopathic, or symptomatic of tumour	4
Metrorrhagia, with peculiar discharge	1
Dysentery	1
Gallstones, subsequent to uterine complaint	1
General dropsy from renal congestion	2
Retention and suppression of urine	2
Hæmaturia from renal calculus... ..	1
Calculus in ureter	1
Gout, rheumatism, and rheumatic gout	4
Excessive discharge of uric acid crystals	1
Hæmoptysis	1

Total, three males, sixteen females 19

The above cases demonstrate the leading diseases or ailments for which thlaspi is effective.

Dr. Heer, of Berlin, in 1857, found it cure the dysuria of the aged with painful micturition and spasmodic retention.

Dr. S. A. Jones reports, in the *Hom. Recorder* of January, 1892, a case of chronic hæmaturia cured, but I have not the journal before me.

Dr. D. H. Stone, in the *Medical Century* of December, 1898, makes this important observation: "In cases where retention of nitrogenous waste-matter was the principal difficulty, I have tried thlaspi and found it of no assistance in eliminating urea and allied substances where the kidney is diseased, as in acute and chronic nephritis, and in uræmia occurring during gestation. . . .

"It is of value as a diuretic, in washing out accumulations of nitrogenous waste-matter below the kidney. I have found it valuable in albuminuria occurring during gestation, where it both reduces the œdema and lessens the quantity of albumen."

Its action upon the secreting tubes and malpighian cells of the kidneys, in promoting the crystallising out of urea and of uric acid, whenever the elements composing these organic compounds are in excess of the normal, seems to me to be *the characteristic* of thlaspi (or capsella, as I prefer to name it) and to ally it to berberis vulgaris, and its hæmostatic power, especially in cases where the blood was poor in fibrine, is undoubted.

The suggestion of that shrewd clinician, Dr. Burnett, that "thlaspi acts upon the uterus much as chelidonium does upon the liver," should be put to the test in practice. For my own part I have always found Burnett's hints of practical value.

Altogether I can endorse Dudgeon's recommendation of thlaspi, and I trust my colleagues will use it freely in their practice. New provings must be made to correct, add to, or corroborate what has been already done by Fincke and Fahnestock.

I must now bring to a close this lengthy paper, thanking you for your patient attention. Next session, if spared, I propose to take up six more remedies, treating them as concisely as is possible, viz., lactic acid, lemna minor, lathyrus sativa, œnanthe crocata, passiflora incarnata, and spiritus glandium quercus.

SOCIETY NEWS.**NEW MEMBERS.**

At the meeting in March the following gentlemen were elected members of the Society:—James Eadie, M.B., Ch.B.Glasgow, of 7, Upper Woburn Place, London, W.C. Thomas Henry Barnes, M.D.St.And., M.R.C.S., L.M., L.S.A., of 148, Lavender Hill, London, S.W.

HOMŒOPATHY IN GERMANY.

At the meeting in March, Dr. Kranz, of Homburg, gave an interesting short account of homœopathy in Germany. The number of practitioners at present is 310. There are three hospitals, and large polyclinics for out-patients in various towns. A society, newspapers and periodicals represent the scientific and literary aspects of the subject. More extended information is given by Dr. Kranz in the *Monthly Homœopathic Review* for June, p. 346.

BOOKS RECEIVED.

Cholera: Its Prevention and Treatment. By S. H. GHOSE, M.D. (Chicago), Corresponding Member of the British Homœopathic Society. Calcutta: The Hahnemann Home, 1905.

Plague: Its History, Symptomatology, Etiology, &c., and Homœopathic Treatment. By S. H. GHOSE, M.D. (Chicago), Corresponding Member of the British Homœopathic Society. Calcutta: The Hahnemann Home, 1903.

Whooping Cough Cured with Pertussin, its Homœopathic Nosode. By JOHN HENRY CLARKE, M.D. London: James Epps and Co., 1906.

EDITORIAL NOTE.

American Ophthalmological, Otological, and Laryngological Society. The Editor has received from Dr. Howard P. Bellows, of Boston, Mass., an announcement of the immediate publication of the *Test-Provings* which have been conducted by the above-named society. The volume promises to be one of great value and interest. Dr. Bellows invites subscriptions to the work from British colleagues. A condensed specimen is given on the next page.

SUMMARY OF PHARMACODYNAMICS AND THERAPEUTICS.

*Extracted from Exchange and other Journals by the Editor, in
collaboration with J. Galley Blackley, M.B., and T. G. Stonham,
M.D.*

Belladonna. *Headache as developed in the test-proving of the
American O. O. and L. Society.*—An advance presentation of the
results of the proving of belladonna as pertaining to the headache
developed by it is made by Dr. Howard P. Bellows, of Boston, Mass.
The results are condensed, in schematic form, into the smallest
possible compass. There were fifty-three provers, and headache
was mentioned in the entries on two hundred and sixty-two different
days. The material is condensed by the adoption of double numbers
placed after each type or symptom, or modality. Thus frontal
headache occurred in thirty-one provers and on one hundred and
thirty-three days. This symptom is accordingly presented thus:—
Headache, frontal (f)^{31·133}. The various headings under which
symptoms are presented are as follows:—headache, sides, direc-
tion (*e.g.* f to o), intensity, duration (*i.e.*, during one day), charac-
ter, time (of day), appearance, including cause (formerly described
as condition), sensations, accompaniments, aggravations, ameliora-
tions, miscellaneous, the system of double numbers being attached
throughout. The following summary quoted from Dr. Bellows
indicates both method and detail as related to the headache of
belladonna. It is chiefly frontal^{31·133}, without specification,^{15·46},
general^{9·20}, vertical^{10·16}, occipital^{7·17}, parietal^{6·9}, supraor-
bital^{4·7}, or temporal^{4·6}, worse on the right-side^{18·72} (left^{6·13}),
extending from before backwards^{4·12}, or from back for-
wards^{4·11}, sharp^{4·7}, throbbing^{4·4}, or bursting in character^{3·3},
occurring oftenest in the afternoon^{9·14}, on waking^{5·8}, or in the
evening^{3·5}, with feeling of fulness^{4·5} or tension^{3·3}, and accom-
panied by flushed face^{3·4}, and in the afternoon or towards even-
ing^{5·7}, and amelioration by open air^{7·8}, by cold air^{3·3}, by
resting^{3·3}, by keeping eyes closed^{3·5}, by pressure^{3·3}, and after
eating^{3·3}. Dr. Bellows claims for this method of presentation

that in its thoroughness and precision it gives a definite value to symptoms they did not before possess. (*Hahnemannian Monthly*, April, p. 264).—ED. (See announcement on p. 287.)

Carbo Animalis in Diseased Glands.—Dr. J. Wilford Allen makes the following remarks with regard to the employment of carbo animalis in glandular inflammation: "The swellings of carbo animalis are always painful, the pains are burning in character and the glands are nearly always indurated; the glands tend to break down and to become scirrhus like. You will think of carbo animalis when the indurated gland is as hard as a stone, and not only are the glands hard, but the same condition is found in the tissues about them. The carbo animalis patient has very severe sweats, these sweats being offensive and causing intense weakness; a peculiar feature of the sweat is that it stains the linen yellow. You will sometimes find the drug called for in hard, nodulated glands, having a blue appearance and with burning, drawing pains. Carbo animalis swellings are always sluggish, slow in appearance, slow in departure. The entire constitution is sluggish.—(*American Physician*, April, 1906).—T. G. S.

Castor Oil Seeds (*Ricinus Communis*). *Poisoning.*—The following case of poisoning is given by Dr. P. C. Majumdar in the *Indian Homœopathic Review*. A robust young man, aged 30, took castor oil seed to give him an appetite. He took two seeds on the night of June 12. Early next morning had a thin but fecal stool; abdomen seemed puffed up. Took another seed with a little table salt at daybreak the next morning, copious vomiting of bilious matter followed, one thin stool at 8 a.m. followed by griping. Another copious stool at 10 a.m. After incessant vomiting and purging continued throughout the day, he consulted an allopathic doctor, who gave some astringent medicine without benefit. Dr. Majumdar visited the man at 8 a.m. on June 14. Stools quite copious, thin, watery, like rice water, every two or three hours; he was also vomiting water tinged with yellow bile in large quantities, the eyes were injected, red and watery. No tenderness, no griping. No urine passed since the day before. Pulse small, thready, and frequent; some restlessness and no sleep, thirst for water. Verat. alb. 30 was given after each stool. Three hours later the patient was still no better. Antim. tart. 6 was then prescribed, one dose every hour. In the evening the patient was better, having had no stool after the second dose of antim. tart. No vomiting since,

but patient restless. No urine. Medicine stopped. There was slight feverishness in the evening, but next morning the patient was better in every respect and thenceforward made a good recovery.—(*American Physician*, February, 1906).—T. G. S.

Corrosive Sublimate. *A Case of Poisoning.*—Dr. Hoffmann, of Brunswick, relates the following instructive case of fatal poisoning after vaginal douches of perchloride of mercury (1 : 1,000). The patient, a young married woman, was found to be pregnant at the beginning of November, 1905. Smart hæmorrhage occurred on December 26, and an allopathic practitioner, with a large obstetric practice, was called in. As there was no urgent call to evacuate the contents of the uterus, he prescribed a vaginal douche of perchloride of mercury (1 : 1,000) followed by plugging; this was repeated every other day until January 16, when he emptied the uterus. Very shortly afterwards the abdomen became much retracted, the patient complained of abdominal pains, and these were followed by repeated foetid purulent stools. In spite of the possibility that the case was one of mercurial poisoning the doctor prescribed a dose of $1\frac{1}{2}$ grains of calomel in order to empty the bowel as thoroughly as possible of its foetid contents (!). The patient's condition, however, became speedily worse. She had severe pains in the throat and on the tonsils a greyish-white membrane formed, which ultimately became gangrenous.

When Dr. Hoffmann was called to the case on January 26, 1906, what first struck him as he approached the patient's bedside was the foetor, which was precisely like that of diphtheria. "The patient lay with sunken eyes, quite apathetic and much emaciated. The lips were blood-red, dry and fissured. In the buccal cavity and on the tongue were a few ulcers, on the teeth a blackish stain; in the centre of the hard palate was a black gangrenous stripe about a finger's-breadth wide, and running transversely to the axis of the tongue. On one tonsil was the remnant of a diphtheritic-looking membrane, the upper part undergoing gangrenous degeneration; the surface of the other tonsil was entirely gangrenous. From the mouth was emitted the above-mentioned diphtheritic odour. The stool, which had been kept for inspection, was an ichorous, pappy stool intermixed with clotted blood. Temperature was 35.2 C. The patient refused all food on account of pain. Dr. Hoffmann administered lachesis. Nutrient enemata were tried, but the bowel would not retain them, and still voided blackish ichor. After the first day or two

lachesis did not appear to help at all, and the patient died on January 29, 1906. During the last three days the temperature never rose above 35.0° C. (95° F.)"—(*Allgem. Homöop. Zeitung*, Ap. 19, 1906, p. 122).—J. G. B.

Curare Relationships.—At a meeting of the Therapeutical Society on March 27, Dr. Gordon Sharp (Leeds) read a paper on native and other plants having some relationship to curare, including (1) *Anchusa officinalis*, alkanet, an imported plant containing an alkaloid; (2) *Echium vulgare*, viper's bugloss, an indigenous plant containing an alkaloid; (3) *Cynoglossum officinale*, hound's-tongue, a common plant containing two alkaloids. He showed that *Anchusa* rendered a frog's skin moist and hyperæsthetic at first, but afterwards insusceptible to stimulation, while the stimulus to the sciatic nerves or the muscles themselves caused contraction. The heart stopped in diastole, and atropine only produced a few contractions of the left auricle. *Echium* caused the same symptoms, with more hyperæsthesia and greater weakness of the muscles. After a large dose no stimulation of the sciatic nerve caused any contraction, though the muscles reacted to direct stimulation. The heart stopped in diastole. *Cynoglossum* rendered the skin moist and very hyperæsthetic; stimulation to either the sciatic nerves or the muscles direct only affected the unpoisoned side. It often acted somewhat like curare, but frequently death occurred suddenly with the heart in diastole. Among foreign plants, the *Delphinium bicolor* and *occidentale* from North America, and the *Delphinium scopulorum* from Mexico, somewhat resembled curare. Their extracts were bitter with a slight smell, and turned red with sulphuric or nitric acids, though delpho-curarine, their alkaloid, gave no colour with either acid. The extract of *D. bicolor* acted like curare; at first it increased the action of the skin, but in two hours the muscles of the poisoned side only contracted on direct stimulation, though on the unpoisoned side they were acted on by stimulating the sciatic nerve. *D. occidentale* at first acted like aconite, increasing all secretions, but later the muscles became insensible to any stimulation either direct or through the nerves. *D. scopulorum* differed from the others, inasmuch as the nerve centres of the cord were greatly depressed, more than the nerve trunks or the motor ends. *D. staphysagria*, or stavesacre, first stimulated the secreting organs and the nerve centres, then depressed and at last paralysed both the nerve centres, the

motor nerves, the muscles, and finally the nerve centres of the heart.—(*British Medical Journal*, April 7, p. 803.—J. G. B.

Ferrum Phosphoricum. *A Proving.*—Dr. John Hutchinson, of New York City, records a proving of ferrum phos. conducted by himself on a man apparently in perfect health. The 30th potency was selected and no information was given as to the name of the selection. One dram of medicated pellets were given with the direction to take one every two hours. This was Saturday evening. Two doses were taken before bed-time. The next day the following symptoms are recorded as having occurred. General discomfort as from fever; inability to command right words for conversation; head feels thick, queer, congested; mucous membrane of mouth, throat, nose, antra, feels sore; bowels relaxed, three movements; thirst absent. Next day much thick mucus dislodged from naso-pharynx. Throat sore left side, pain extending from within to the external auditory meatus. Soreness shifts to right. Discontinued medicine on Monday after twelve doses. Symptoms increased. Urine pungent when voided, solids increased. Sleep restless, broken. Brain active when awake during night. Symptoms were practically gone on fifth day after beginning proving. Proving was renewed in six weeks' time. Provers throat normal, ferrum phos. 30 every two hours. Occipital throbbing, pain in left eustachian tube, then in right after third dose; restless sleep, desire for more oxygen; severe pain and tenderness in teeth, disturbing sleep. Two teeth, stopped five years, aching for the first time. Sense of elongation. Impossible to close jaws without great pain. Most severe one to two a.m. Pain over left side of face increased by warmth, throbbing, with sweat over head and face. Submaxillary glands enlarged right and left, chilliness during day. Face somewhat flushed. Symptoms recurred repeatedly for a week. Prover felt ill, restless, apprehensive, agitated. The symptoms were more persistent than in the first proving.—*Hahnemannian Monthly*, April, p. 268)).—Ed.

Lycopodium in Meningitis.—Dr. Freeman, of Brooklyn, N.Y., records the following case: A boy, aged 6, blonde, blue eyes. Been ailing for three or four months. For the last few weeks has been growing rapidly worse. Two other children have died of tubercular meningitis. A third child died of marasmus. The mother is of a tubercular diathesis; she has had seven children in nine years and is an invalid. The father has had atrophic rhinitis for years; he had gonorrhœa twice before

marriage, and he is a reformed drunkard who admits having had delirium tremens twice. During the first week of treatment arsenic 200, bryonia 200, and belladonna 200 have each given temporary relief only, and he has continued to grow worse. The temperature now reaches 106° F. in spite of sponging, which has no appreciable effect on it. He is either in a stupor, with eyes and mouth half open, or he is screaming with all his might. The pupils are dilated, and there is great photophobia. General hyperæsthesia is marked, and the least touch or noise or jarring on the floor fearfully aggravates the suffering. There is marked rigidity of the neck muscles and retraction of the head. Spasmodic action of the alæ. Frequent propulsive vomiting. Intense thirst for cold drinks; swallows glassful in three or four gulps, and screeches for more.

Lycopodium 200 four doses, one every hour, gave considerable relief, so that he passed a comparatively easy night. The next forenoon there being a return of violent symptoms with flushed face and warm sweat, opium 200 was given hourly for three doses with benefit. Lycopodium was again given that evening, and thereafter every afternoon and evening in the C.M. potency, a few doses for about a week. Convalescence extended over a period of about six weeks. Six months later he contracted whooping cough, but made a good recovery, and has been enjoying good health ever since.—(*North American Journal of Homœopathy*, April, 1906.)—T. G. S.

Malaria Officinalis in Malaria.—Dr. J. W. Allen quotes the following case, which was sent to him by a New York physician : “ The patient at the time of my treatment was a minister of one of the Fifth Avenue churches, and had been a sufferer from intermittent fever for seven years. His father, a physician of the old school, had tried all the routine remedies without success. The usual malarial parasites were present, but it was felt that the case must be a complicated one, because he had such pains in his back and legs that he was obliged to go on crutches. He at last resolved to give up old-school drugging and came to me. Remedies used : First, sulphur as a constitutional remedy, for the family history showed a psoric taint. Two doses of sulphur were given, two weeks elapsing between the doses. He had some very characteristic symptoms of aconite, brought on by cold dry winds, to which he had been exposed, showing that aconite is the acute of sulphur, and will often precede and follow sulphur nicely. His symptoms changing I gave nux vomica, but without

success. I then found myself much puzzled. I then worked the case out carefully under Boeninghausen to find that nux still stood high, but I was not satisfied to continue giving nux. In studying Clarke I found in his dictionary the similimum in malaria officinalis, which made a complete cure.—(*North American Journal of Homœopathy*, April, 1906.)—T. G. S.

Momordica Charantia.—Three cases are published by B. B. Chakravasti, L.M.S., illustrating the value of momordica in cholera or choleraic diarrhœa. The following are mentioned as the characteristic symptoms calling for this remedy: watery yellow stools mixed with mucus, bloody forcible expulsion; bilious frothy vomiting, sour to the taste; insatiable thirst, wants to drink in quantity but cannot retain it; cutting pain in the abdomen, flatulence, burning in almost every case, rumbling; suppressed, scanty, high-coloured urine; dry, coated, white tongue; prolapsus ani with burning.—(*Homœopathic World*, April, p. 164.)—ED.

Neuralgia. Treatment by Electricity.—Dr. Chas. A. Davis, of Washington, draws attention to the use of the high frequency current in cases of "tic douloureux," and states he has always succeeded in affording temporary relief by this means, excepting in one case. The following case is cited as one in point. Mr. W., aged 50, of nervous temperament, had suffered for three years with pain in the outer canthus of the right eye, extending over the temple and brow. The pain and distress were so great he had been obliged to give up business. He had short periods of relief. It was a most unpromising case. He was placed under the influence of a Pifford's hypostatic transformer, which consists of a series of Leyden jars associated with an induction coil, stimulated by the high tension current of a static machine, the application being made to the head by the use of a glass vacuum electrode. Relief was afforded directly the current was turned on. Although the sensation of the electricity was almost *nil* the soothing effect on the pain was complete. In a minute's time the patient remarked: "I feel better, more like myself than I have felt for months." He had applications daily for two weeks, with constant diminution of the symptoms; the intervals were then prolonged from every other day to once a week. At the end of six weeks he was discharged, cured. In another case, a man, aged 64, suffered from the well-known form of "tic" of the right inferior dental nerve. Five applications of the current caused the

attacks to cease for a time, but they recurred after the application of an electrical massage machine by the hairdresser. He was still under treatment at the time of writing.—(*Medical Century*, February, p. 39).—ED.

Pulsatilla in Cough.—The following case recorded by Dr. Gee, illustrates the characteristic symptoms of the pulsatilla cough: H., aged 13, had had yearly bronchitis for seven years. In September he caught a cold in the head, the nose was stopped up, some sneezing, a cough followed. The cough was excited by tickling in the throat as from a feather; coughs more in the house, from reading to himself, sitting still, after running, while lying down. Better out of doors; while running or walking, sitting up in bed, no pain nor headache with the cough; after hard coughing raises a little white thin mucus. Coughs once, then waits about ten seconds and coughs again. Coughs more in the evening about 6.30 p.m., unless he goes out. Has thirst during the coughing spells and in school. Drinks little and often. Eats meat but dislikes fats. Pulsatilla (dose not stated) was given about 2.30 one afternoon. Four days afterwards he reported that it stopped the cough and he was able to go to sleep the first night and each succeeding night till he took another cold while at a skating rink. One dose more of pulsatilla put an end to the whole trouble.—(*American Physician*, March, 1906).—T. G. S.

Sparteine.—Yet another heart tonic has been introduced in sparteine, the alkaloid derived from *Cytisus scoparius*. It appears to combine the effects of digitalis and veratrum viride. Digitalis is to be regarded as a heart tonic, increasing the force and lessening the frequency, but at the same time raises arterial tension throughout the system. Veratrum reduces the force and frequency of the heart's action, and at the same time dilates the arterial system. Sparteine adds tone to the heart's action as greatly as digitalis, but instead of contracting the arterial system and raising blood pressure, as digitalis, it appears to have directly the opposite effect. Under its influence the pulse is soft, full and compressible. There are no bad effects from its use in diseased conditions, as with digitalis or veratrum. The dose required to produce the physiological effect is $\frac{1}{2}$ to 2 grains.—(*Therapeutic Gazette*, March, p. 194, condensed from article by Petley in *Georgia Practician*, November, 1905).—ED.

Zea Italica (*Ustilago mädidis*).—Dr. Tessier, père, in the course of a discussion at the French Homœopathic Society, gave

the following schema of the symptomatology of *Zea Italica* (which appears to be identical with *Ustilago maidis*, and, like it, is credited with being the exciting cause of pellagra).

After doses of six grains of the tincture per diem for several days, the action of the drug persisted from two to nine months.

Fever.—Abundant sweats; pulse at first accelerated, then weakened; palpitation.

Moral.—Mania for bathing; inclination to suicide, particularly by drowning; inclined to be irritable and to weep without cause.

Head.—Heat of head; confusion of ideas; somnolence during day; headache; vertigo (relieved by drinking wine).

Skin.—Pruritus; itching in various parts of the body; eruption of ecthyma; sunburn on arms and hands. Cure in cases of psoriasis, eczema and ecthyma.

Eyes.—Burning of the eyelids; dilation of pupil.

Throat.—Burning in gullet.

Appetite.—Distaste for food, following voracity; voracity increased.

Stomach.—Pyrosis; nausea; vomiting; all disappearing under the influence of wine.

Abdomen.—Enteralgia; soft stools; diarrhœa.

Urine.—Urine red; density increased.

Menses.—Metrorrhagia.

Trunk and limbs.—Muscular weakness; loss of weight; sensation of boiling water down the back; contraction of muscles, especially of lower extremities; pronounced clonic movements; tetanic contractions.

Nervous system.—Paralytic seizure, causing him to fall to one side.—(*Revue Homœop. Française*, March, 1906, p. 99.)—J. G. B.

JOURNAL
OF THE
British Homœopathic Society

No. 4.

OCTOBER, 1906.

VOL. XIV.

All communications and exchanges to be sent to

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A STEP FORWARD IN THE TREATMENT OF
CANCER.¹

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ON April 7 there appeared in the *Lancet*, whether by chance or by arrangement I cannot say, two papers on the treatment of cancer. Both papers own a dual authorship—one by Drs. Paine and Morgan, pathologists to the Cancer Hospital, Brompton, and the second by Drs. C. Jacobs and Victor Geets, of Brussels. Both articles discuss cancer from the bacteriological point of view, and in particular with respect to the rôle of the *Micrococcus neoformans*. So far they are in agreement, but, when it comes to the question of treatment, that discussed by the English authors is based on the antitoxic serum of Doyen, while the Belgian authors introduce—and as far as I know for the first time—the treatment by a bacterial vaccine. This is not the place to

¹ Presented to the Section of Surgery and Gynæcology, May 3, 1906.

discuss the theory of Doyen's serum. In passing I may say that last year in Professor Doyen's clinique, in Paris, I had the advantage of seeing some of his cases. Judging by the statements made to me by the doctor, the nurses, and especially the patients, some of his results were good—that is to say, cases we should ordinarily regard as hopeless were greatly ameliorated, subjectively and objectively. But these results are far from being universally repeated, and I am not aware that there is any guarantee that different specimens of the serum have the same properties, nor any but empirical guides to the dose and its repetition. Indeed, both the articles I have referred to condemn the serum of Doyen as useless.

On a very different footing is the vaccine of Dr. Jacobs. It is not an antitoxin, its dosage is measured by counting the micro-organisms, and the repetition and size of the dose is determined by regular examination of the patient's blood.

Let me remind you at this stage that the term vaccine has entirely lost its original etymological significance. A vaccine is defined by Wright as any substance which, introduced into the organism, brings about the formation of protective substances. It is obvious, therefore, that such substance may be living or dead, inorganic or organic, hence a metal or its salts, a vegetable poison—such as atropine, or a bacterial toxin, or an animal poison—such as our own *crotalus*.

Now, as to the *modus operandi* of such protective substance, a theory has been advanced chiefly as regards bacterial poisons. It is that the toxin combines with antibodies existing in the blood and removes a certain portion of these protective substances. The result is a stimulation of the blood cells to produce a fresh and excessive supply of the protective substances used up by the toxin injected.

Some such explanation of the action of drugs is not unfamiliar to those of us who have sought to explain the action of a homœopathic remedy. As regards tuberculosis the stage of theory is passed and the practical application is attracting the attention it deserves. So recently as our last meeting Dr. Ham explained the action of the vaccines

with special reference to tuberculosis. A recent French writer, Dr. Backer, points out that that congeries of diseases has advanced *pari passu* with cancerous diseases. It is interesting that the newest and most successful method of treatment for the one is now extended to the other. The vaccine treatment of cancer is based on an exactly similar principle. In each case the dead bodies of a micro-organism together with the contained toxins are injected into the circulation of the sufferer. In the case of tuberculosis it is the bacillus of Koch; in the case of cancer it is the *Micrococcus neoformans* of Doyen. A word as to the history of this micrococcus may be permitted. Nearly twenty years ago M. Doyen deposited a sealed packet at the Académie des Sciences de France. In the year 1904 it was opened at his request, and found to contain a description of a micro-organism which he stated he had found present in tumours, innocent and malignant. This micro-organism has certain features of colour, method of growth and life history which serve to distinguish it from the many other cocci known to bacteriologists. Although it can hardly be said to hold the same position with respect to neoplasms that Koch's bacillus holds with respect to tuberculosis, it nevertheless is a feature of some constancy. If a gland is removed, *e.g.*, from the axilla in a case of a cancer of the breast, or if a portion is removed aseptically direct from a malignant tumour, the bacterial growth which takes place is *always* the *Micrococcus neoformans*. It can be grown in ordinary alkaline bouillon and reproduced indefinitely on agar-agar.

From this organism a vaccine is made in the same way as Dr. Koch's new tuberculin. It is administered in small doses at intervals regulated by its effects on the patient. These effects are ascertained by estimating the opsonic index of the patient as described for tubercle bacilli by Dr. Ham at our April meeting.

The technique is simple enough for any one with a laboratory at command and a little patience. It requires time and care.

Now, as to the *bonâ fides* of the thing: The *Lancet*

article struck me with its genuineness and moderation, and fascinated me with the prospect held out that some day at least cancer might become a curable disease. I decided to investigate at first hand the claims put forward by Dr. Jacobs, and having procured an introduction to him, I received a very kind invitation to visit his institution and see all about his treatment of cancer cases. He suggested that a week would enable me to do that. Accordingly I have spent a week in Brussels, most of the time in the laboratory of the Institut Ste. Anne. The institute is a small hospital, of which Dr. C. Jacobs is the chief. Dr. Victor Geets is his assistant, and does the chief part of the bacteriological work. Of his care and thoroughness I can speak from abundant personal knowledge. Of the fearless honesty of Dr. Jacobs no one who heard his paper at the British Gynæcological Society could have an instant's doubt. I was told that anonymous rumours stated that Dr. Jacobs was making his fortune by means of a secret method of treatment. As regards the fortune, both Dr. Jacobs and Dr. Geets assured me this was so far false that, in the quaint words of the former, his receipts had been hitherto "zero francs et zero centimes." As regards the secrecy, if he himself has not published the details of the method it is simply because it is already fully reported by Wright and Douglas and Bulloch, as regards the tubercle bacilli, staphylococci, &c. Every detail was shown and explained to me in the fullest and most friendly manner. As to results, it is not yet claimed that cancer has been *cured*, for the method has not been in operation much more than a year. I saw several breast cases—recurrences after operation. Two of them were spreading in the skin of the chest wall to so considerable an extent as to merit the description "en cuirasse." I was told that when they first came they had a red, angry-looking aspect and presented one continuous surface of fixed indurated infiltration. When I saw them after four or five injections, the colour had faded and the surface was becoming broken up into islands of new growth much less hard and less fixed. Pain and swelling were lessening. In two other cases there had been a local ulcera-

tion which had healed. In a fifth the patient volunteered, as Dr. Jacobs went his rounds, that her dress sleeve, which previously fitted tightly on her, was now quite loose.

A case of cancer of the uterus, which had spread to the rectum, had had, I think, four injections. Before admission the patient was suffering greatly at night with tenesmus, and passing bloodstained mucus, causing her to get up fifteen or sixteen times every night. When I saw her for several nights she had only been up twice, and on one occasion not at all.

I saw also a patient who had had two operations for rapidly-growing cancer of the parotids (bilateral); recurrence was again taking place, and the patient could not button his collar. After a few injections the swelling on the right side had entirely disappeared and was lessening on the left, and he wore his collar easily.

One of the cases reported by Dr. Jacobs was that of a woman with inoperable uterine cancer. After treatment the uterus became movable and was removed. The reason for surgical interference in such a case which is doing well, is the belief that the tumour is a centre where poisons are formed and from whence they are passed into the general circulation. If this source of infection is removed it is believed that the constitutional treatment has a better chance. Anyhow it is now nearly a year since that case was operated on—a case as I said pronounced inoperable a little while before—and no recurrence has taken place.

But operation is not always carried out. In some cases it is declined; in others it is impossible. One case of pelvic cancer recovered without operation, the symptoms all disappearing, only a hard rectal ring being left, and the patient was at work again.

A very bad case of recurrence of epithelioma of the vulva was attending the clinique. Dr. Jacobs had done an incomplete removal, continued growth taking place after operation. This was controlled by the injections, and the patient appears to be doing well. One of the earliest signs of improvement is that the well-known cachectic tint rapidly disappears. This is a very marked and encouraging fact.

Some cases appear from the first foredoomed to failure.

If, after two or three injections, there is no rise in the opsonic index, it has seemed to the authors of this treatment that it is better to desist. The injections rapidly use up the protective substances in the blood, and the reactive powers of the patient are so low that no increase follows. Such cases rapidly go down hill; so do those where an overdose is given and the negative phase fails to be followed by the expected positive. It appears from this that a weapon of great power, and one not without danger, is in the hands of the physician. I am open to correction, but it seems to me from all I have heard and read that there is a great tendency to give unnecessarily large doses. It is believed that a "negative phase" *must* occur. In their report to the Académie Royale de Médecine de Belge Drs. Jacobs and Geets wrote: "A considerable diminution of the dose meets the necessities of the case still less. The negative phase is either totally wanting or is so transitory that the blood examination fails to detect it; the positive phase is equally lacking, and the degree of immunity remains what it was." . . . "The question of dose is of first importance—too weak, the reaction passes unperceived; too strong, it may aggravate the condition and produce a general mobilisation of the infecting microbes."

The guide to strength and repetition is the blood examination; the best time for an injection being when the positive phase begins to decline. In bad cases, or those reacting but little, a small dose is required. Of course, it must be remembered that though the term "small" is used, and a thousandth of a milligramme may sound little, such a quantity represents, say, from one hundred millions to seven hundred millions of bacteria. It is not easy for those accustomed to the usual dosings by drugs to remember that it is better to aim at the lowest dose which will do the work needed rather than the highest which can be borne.

Why is this treatment more promising than any we have before heard of? Because it is more scientific than any previously known, and the scientific principle at its root is that of "similarity." Various drugs have from time to time been used for the treatment of cancer. Probably the most generally useful in relieving such cases is arsenic.

But its similarity is comparatively remote; *here* is the poison of the cancer itself modified by culture, &c., and its phenomenal success is because the similarity is so great. It is possible that a still greater measure of success may be obtained by taking the culture from the patient's own growth and preparing a vaccine from that. This would approach identity and isopathy; at any rate it might fairly be considered a simillimum. One other point only touched upon by Dr. Ham's paper is that of multiple infection. In many cases of superficial cancer or growth near a mucous surface, a mixed infection may have taken place, and the opsonic index to other micro-organisms must be tested. Or *there*, with especial advantage, the self-vaccine might be used.

I was very much struck by seeing how closely the curve of the opsonic index was followed by the clinical symptoms and general well being.¹

Gentlemen, though this treatment is in its infancy it appears to me to be based on sound principles, and if properly carried out to be one of great promise. The history of past "cancer cures" is one of such dismal failure that I hesitate to speak with the enthusiasm I feel. In a year's time I hope again to bring the subject before you with a record of personal experience which shall carry weight with it. In the meantime I venture to take upon myself the responsibility of commending it to you, that the subject may be investigated by many besides myself.

Dr. CHARLES E. HAM said that a cure for cancer would be welcomed, but so many remedies had been brought forward in recent times that he thought any further remedy ought to be thoroughly tested before being made public. The presence of the micrococcus of Doyen in all malignant growths had not been confirmed by many well-known bacteriologists, and certainly this particular organism after injection had not caused cancer. Dr.

¹ With a higher index the conditions, local and general, improved, and *vice versa*. In the majority of cancer cases the opsonic index—in other words, protective power—is, to begin with, low. In favourable cases it progressively rises with the treatment. In a few cases even without treatment, where the patient is making a good fight, the index is found to be high, and it may be still further heightened by treatment.

Neatby, in his interesting paper, said that this micrococcus was not only present in malignant growths, but also in those of a benign character. A malignant growth is very different in nature to a benign, as can be shown by examining the nuclear changes, and if this organism is actually present in both varieties it could scarcely be looked upon as the cause of cancer, and would not be expected to be a specific for malignant tumours. The dose of the nosode to be given was one of the most difficult things to settle. He (Dr. Ham) had given more attenuated doses than Professor Wright, and with very good results, even when the nosode was taken by the mouth. The negative phase was very slight, but the opsonic index had risen gradually from 0·7 to ·85 and ·9.

Dr. BURFORD said this was an occasion when the topic was dealt with from the point of view of the pure physician, and he could not but congratulate Dr. Neatby upon putting the matter succinctly before them. In mediæval times it was the custom for the leaders among the younger men to be peripatetic, and to travel about from university to university, seeking new facts and new ideas, and the gentlemen who so distinguished themselves in their youth were as a rule the protagonists of later years, and their names had come down in history. He thought the gynæcologists of the London Homœopathic Hospital might be held to approach very closely to their forebears, and Dr. Neatby was to be thanked for devoting his holidays abroad to personal investigations of this character. It argued a very great deal, not only for the initiative but for the receptivity of the minds of their gynæcologists, that they should be thus apt in absorbing new ideas. The air in later times had been full of cancer problems and cancer treatment, and if there was one thing that was more prominent than another, it was the distinct but altogether new and practical trend of the treatment of cancer from the surgical to the medical side. Here were two of the most distinguished cancer surgeons of the day, Dr. Doyen and Dr. Jacobs, turning their attention distinctly to its medical amelioration or cure. Whatever might be said about the chance of cure, and how inoperative it is in certain cases, he held that the fact of three cases being cured justified a trial of the treatment, even though in the ninety-seven remaining cases it should have failed—presuming that those three cases were otherwise held to be incurable. If the treatment only eventuated in these cures, he held that that would have justified the treatment, even though it should not prove a panacea in all and every case. Dr. Jacobs had been rather taken with Dr. Doyen's treatment, and had come to

the conclusion that there was a very great lacuna to be filled by the adoption of methods known to the physician. Some time ago a patient presented herself to him with all the symptoms of sarcoma in the left flank, and operation showed a diffused infiltrated growth in that region. A small piece was excised in order to make assurance doubly sure, and the incision was stitched up. He remembered telling the husband that his wife's prospects were most unsatisfactory. The growth was subjected to expert observation, and the report was that it was one of the varieties of fast-growing sarcoma. That lady at the present time was walking about in the heyday of health, and had added three stones to her weight. Every evidence whatever of the tumour had disappeared, save and except the scar of the incision, which he had made for its exploratory investigation. She was put under a medicine which had been very much decried in various quarters of late, but from which his patient had received the most signal benefit—cacodylate of soda. Another lady, who came to him some time ago, had cancer in the breast. She had been sent up from Brighton in a great hurry. He did not think he had ever seen a more disseminated case of cancer of the breast. It seemed that it was a foredoomed case, and that operation would simply add to the stress of the patient's condition. But having begun, they were bound to go on, and the breast was removed. In a comparatively short time nodules were observed in the line of incision; these were removed. The patient then went for a few months, and the nodules recurred and were again removed. In another two months they again occurred and were again removed. She went for another month, and there was evidence of another nodule. Both the lady and he were tired of this unsatisfactory procedure. The lady was a single woman of about 40, and he suggested, as a forlorn hope, to remove the ovaries. He removed both the ovaries, and put the patient on cacodylate of soda. That was a year and a half ago; the lady had gained over a stone and a half in weight, and had not had the least hint of any nodular return in the region of the scar ever since.

Dr. STONHAM said the lady referred to by Dr. Burford had been under his observation. She soon began to improve under the cacodylate of soda and to put on weight. Three weeks ago was the last time she came up to see him, and there was then not the slightest evidence of any growth whatever, and she was in the most perfect health. While taking the cacodylate she exhibited the physiological results of the drug in a certain amount of keratosis of the skin; it was not till that appeared that the

drug was stopped, and he did not think it had been necessary to repeat it.

Dr. BLACKLEY, as an example of what was possible in the treatment of malignant growths by drugs, mentioned the case of a lady, now 62 years of age, who first came to him about sixteen years ago with a growth in the recto-vaginal septum (presumably malignant) about the size of a bantam's egg or a small Tangerine orange. After a few months Dr. Burford saw her in consultation with him and expressed no doubt as to the malignant character of the growth, and also as to the impossibility of surgical interference by reason of its position. The patient was placed immediately under the influence of arsenic in tangible doses, which had been repeated at intervals until about two or three years ago. He gave it in fairly substantial doses of two to five minims, twice a day, until the patient began to show signs of physiological symptoms. The growth was reduced now to about the size of a small walnut. The lady had put on more than a stone in weight, and was in very fair general health. There was still some mechanical trouble with the bowels, which was obviated by enemata once or twice a week.

Dr. SPEIRS ALEXANDER said the objection that this micrococcus had not been found in this country in ordinary malignant growths, and yet in spite of its absence the growths were malignant, might be met by making a vaccine from the patient himself, so that whether the micrococcus was present or not they could thus get a vaccine which would be adapted to the particular case to be treated. It was possible, in that way, to adapt the system to every variety of malignant disease that might present itself. With regard to cacodylate of soda, its use must be more or less empirical, unless they had definite indications for its use. The question arose under what circumstances was it to be used, and in what class of cases could they tell beforehand that it was likely to be useful? It had had a great vogue in the last few years, and now and again one met with some very remarkable results from it. He had seen glandular enlargements entirely disappear under its use. In the treatment, for instance, of exophthalmic goitre, he had seen the most urgent subjective symptoms removed by it, without any diminution of the goitre itself or of the exophthalmos. Dr. Burford had referred to a case in which the ovaries were removed and cacodylate of soda was also given. He (Dr. Alexander) thought that the good results might be due to the cacodylate of soda rather than to the removal of the ovaries.

Mr. KNOX SHAW said if it were not for the fact that cacodylate of soda, arsenic, and all the other remedies that had been used for years for carcinoma, failed far more frequently than they succeeded, they would not now be still hunting for some good and reliable method of treating cancer. His quarter of a century's practice had made him think that the failures in the treatment of cancer by any method were far more than the successes. He would ask Dr. Neatby whether it was essential that the *Micrococcus neoformans*, which could be found in tumours, both innocent and malignant, should be the basis of the treatment. He understood that in preparing vaccine they took a growth and made a culture from the growth on the same lines as Burnett's bacillum. Now, must it be this micrococcus that is in the vaccine, or could it be that there was something else which they did not know of yet? If that were the case, they might with justice go on on the lines on which they were doing, or which were indicated by Dr. Neatby, without necessarily feeling that they were attempting to cure a disease by a micrococcus which was not special to that disease. Should they advise patients to submit to any form of treatment before operation, or should they (as he understood Dr. Jacobs advised) remove the disease first and treat the patient afterwards? Dr. Jacobs said that as long as the disease is in the body, it is forming so many toxins that it is practically impossible for the patient to antidote the poison, but if you removed the disease as far as possible, you enabled the remedy to set in circulation in the system the antibodies which are going to cure or help to cure the disease. Personally, if he had any growth which was at all within the reach of the surgeon, he would beg the surgeon to remove the growth first, and treat him afterwards. If they tried treatment first and it failed, there would come a time when it was absolutely impossible to do anything by any form of surgery. He believed the practice that was inculcated now to be the right one, namely, if you are to be operated on you should be operated on at once, as soon as the diagnosis is made. If one waited until the patient thought it was necessary, then one would find the time had gone past. It was a very serious responsibility for any medical man to treat a patient with a malignant growth in the hope of any cure. In the surgical world they believed that a certain percentage of cases would not recur. Mr. Watson Cheyne took a very hopeful view and said 50 per cent. of his patients had no recurrence; but he would take a more modest view, and would say 25 per cent. He did not believe that 25 per cent. of similar cases were cured by medicine.

Dr. CLARKE said if Dr. Neatby had prosecuted his inquiries a dozen years ago, and had gone to Dr. Burnett, he would have found very much the same kind of thing. Dr. Burnett did not make cultures, but he took the virulent material from the malignant tumours and had them attenuated up to the infinitesimals, and used them with very great success in cases of malignant growths. Besides, there were plenty of cases of cancerosis, as well as of tuberculosis and vaccinosis, in which there were no actual malignant manifestations, but a peculiar cachectic condition which was related to them. He thought the speakers had rather neglected what had been done by homœopaths; however, in this, as in other things, allopaths were teaching the world homœopathy, and it generally happened that homœopaths were more anxious to learn homœopathy from allopaths than they were from homœopaths.

Dr. GOLDSBROUGH said an analogy had been offered by Dr. Neatby between the pathology of tuberculosis and that of malignant growths, but the history in the case of the neoplasm in these diseases was not quite parallel. For instance, a new growth in tuberculosis compared with cancer was practically a benign growth. He would therefore suggest that in research along these lines great caution should be adopted in inferences from facts based on this analogy.

Dr. HAWKES (in the chair) said he was sure Dr. Neatby would be gratified by the discussion. Unfortunately they had a great deal of cancer in Liverpool, and only that morning, when a patient was under chloroform, his colleague had deplored that they did not get their cases early enough, and that, on the contrary, the patients often came to them when nothing could be done. It was Dr. Burnett's early experience of arsenic in a case of epithelioma of the lip that helped to make him (Dr. Burnett) a homœopath.

Dr. NEATBY, in reply, said he must plead guilty to a certain degree of prematureness in presenting the paper. It would not have been put before them that evening had it not been for the exceptional circumstances which Mr. Knox Shaw mentioned at the opening of the meeting. So far as he was concerned it was quite a scratch paper, but at the same time he regarded the discussion as a little discussion *en famille*, which was not quite the same thing as publishing it to the world, and certainly he was not presenting it as a definite claim of cure, but as a claim that Dr. Jacobs' treatment was worthy of investigation. In reply to the question: In what percentage of cases the *Micrococcus neoformans* had been found? that varied a great deal with the

observers. It had been found in this country in about 20 per cent. of cases, but Dr. Jacobs and Dr. Geets had found it in about ninety per cent. They said it was best found in the glands that are affected at some distance from the original growth; it was quite in the outposts of the disease where it was to be found in a pure condition; that is to say, not complicated by other micro-organisms. He had stated, as Drs. Doyen, Jacobs and Geets had stated, that it is found in other than malignant tumours. It is sometimes found in an innocent and a malignant tumour in the same patient; it was found in scirrhous of the breast and lipoma of the buttock. Dr. Jacobs did not claim that it was in any definite specific sense the cause of cancer, but it was his opinion that, if not the cause of cancerous cachexia, it was at any rate associated with it. He had been very much interested in hearing what Dr. Ham said about reducing the dose, and that the results were so far good in the case of the vaccine of the tubercle bacillus. He would like Dr. Ham to tell them whether, when the drug was given by the mouth, the results took longer to accomplish than by the method of hypodermic injection. It was quite clear that it was safer, because in these cancerous conditions a very little over-dose would so reduce a patient's power of reaction that he would rapidly go to the bad. He thought the vaccine treatment of cancer did not claim to replace operation, but it had a field where operation could not take place, and it could supplement an operation in the direction of preventing recurrences. Mr. Knox Shaw raised a very important and extremely interesting question when he asked whether there was anything besides the *Micrococcus neoformans*. He thought it was very possible there was, but so far it had not been discovered. It was not a something that could be grown, and if a micro-organism could not be cultivated from the portion of the gland or the tumour that was put into the bouillon, there was practically nothing to make a vaccine from, though it might be that a mere solution of the juices or virus of the tumour might answer the purpose. He had been very much interested to hear from Dr. Clarke that Dr. Burnett, years ago, had used a somewhat analogous preparation. Everybody had heard of Burnett's bacillinum, but he had not heard of this carcinoma preparation, and it was especially interesting to hear of its effect in the cachexia which is associated with cancerous and other diseases. He thought perhaps that Dr. Goldsbrough had a little misunderstood him when he suggested that he had compared the pathology of cancer and of tubercle; the comparison he had made was between the preparation of the two vaccines, which were on all fours.

SOME POINTS IN THE SURGICAL TREATMENT
OF NON-CANCEROUS DISEASES OF THE
STOMACH, ILLUSTRATED BY A CASE.¹

BY C. KNOX SHAW.

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THE points to which I want to draw attention will be brought out as I describe the following case, for they illustrate some important features in the development of the surgery of the stomach. As a starting point, we may, I think, take it as a proved and established fact that surgery can now offer certain very definite results in the operative treatment of non-malignant diseases of the stomach.

In the spring of 1899, just about seven years ago, I saw in consultation with Drs. Byres Moir and Herbert Nankivell an emaciated, delicate-looking woman in her 57th year. She had never been strong, and had always suffered more or less from indigestion. For the last five and a half years she had complained of severe gastrodynia, and a year and a half after the onset of this symptom she had hæmatemesis, followed by obstinate vomiting, which was so frequently recurrent that she had become practically a bedridden invalid.

Here was clearly a case of gastric ulcer with its sequelæ, pain, vomiting, gastric dilatation and malnutrition, which had failed to be relieved by the most careful medical treatment. The appearance of the patient and her physical condition made one suspect the possibility of some malignant disease, for most are now agreed that a carcinoma may develop in the site of a gastric ulcer. Here I may raise my first point: given a condition such as I have described, is it not the duty of the physician to raise the question of surgical treatment: "to remove the hindrances to the cure?"

Here are organic changes of a very chronic, intractable

¹ Presented to the Section of Surgery and Gynæcology, May 3, 1906.

nature, but which test the diagnostic power of the physician, for he must carefully discriminate between them and the somewhat similar corresponding functional symptoms observed in neurasthenic cases, but which should be, and generally are, overcome by careful therapeutics and prolonged rest. I hold that every possible clinical method of diagnosis should be exhausted before using surgery as a means to that end. When an abdomen is opened in a gastric case we ought to be sure of finding a condition that really calls for surgical interference.

In the organic cases not only do we have to deal with the effect of the cicatrization of the ulcer, especially if it is near the pylorus, but to the adhesions caused by the perigastritis frequently accompanying gastric ulcer in its acute stages, which adhesions, by anchoring the stomach, interfere with its peristaltic action, and so give rise to an intractable dyspepsia. Dr. Moir and Dr. Nankivell having decided that at this crisis of the patient's history surgical interference was necessary, the abdomen was opened. On bringing the stomach into view a cicatrised ulcer was seen, puckering and stenosing the pylorus. (I referred to this case at a discussion on malignant affections of the stomach at this Society, in November, 1899). Seven years is quite a long time in the development of modern surgery, and in these seven years I have learned much. All new operations have to stand the test of time, and although they may appear to give brilliant results at the moment, we must wait and see what the ultimate issue will be; then we can leave the uncertainties of a theoretic opinion for the sure knowledge that comes from experience. Having found the ulcer what were we to do? Several operations were before us, pylor-ectomy, gastro-enterostomy, pyloroplasty or pylorodiosis (Loretta's operation). Such a severe operation as pylor-ectomy can rarely be justified for such a condition as this, and I have not yet come across a case where it seemed in the least called for. Loretta's operation—forcible divulsion of the pylorus—has never commended itself to me; I have tried it at times, but have given it up. We had, therefore, to choose between gastro-enterostomy and pyloroplasty, and

I chose the latter. On the face of it, this seems an ideal operation; it consists of dividing the anterior wall of the pylorus longitudinally and then uniting the wound transversely to its axis by a double row of sutures; it is easily and quickly done. After the operation the patient made a rapid recovery and was soon eating, and enjoying, and digesting solid food. For the greater part of the time since the operation Miss W. has been under the observation of Dr. Frank Nankivell, and to him I am indebted for the subsequent history of the case. He says she went on well for some time, travelling abroad and enjoying comfortable health, until the beginning of 1905, when, after three months of intermittent indigestion, she had an attack of hæmatemesis in the April of that year. She had rectal feeding for sixteen days and then went to Brighton. On her return home she had a return of her indigestion, with pain all down the right side, liver especially, flatulence, constipation and vomiting. The attacks of indigestion recurred, the intervals becoming shorter and less complete. Uric acid was freely passed just before the attacks. There were various nervous symptoms, such as fidgets, pricking of limbs, and burning of the feet. The gums became very sore and ulcerated, so that she could not wear her artificial teeth. The attacks of indigestion were accompanied by fever for two or three days, the temperature rising to 101°, or even higher. For some weeks, at the end of 1905, she was confined to her bed, only able to take the very smallest quantity of food, because of both pain and vomiting; the vomit at times consisting of large quantities of fluid mixed with food. She was relieved for a time by this copious vomiting. She was seen by Dr. Moir, and, on December 30 last, Dr. Nankivell asked me to see her again, when I found her in the condition described. Her stomach was considerably dilated, her tongue furred and rather dry, and her body much emaciated. It appeared to us all that unless some radical change could rapidly be effected her life must very soon end.

A few years ago I saw in this hospital a very similar case where I had done a pyloroplasty for cicatricial stenosis

of the pylorus on a man, under Dr. Blackley's care, who had, to relieve his symptoms, washed out his stomach daily for eight or nine years. The operation was followed by immediate relief, but in course of time all his old symptoms returned, and he ultimately had a gastro-enterostomy performed with a more permanent result. I therefore advised that a gastro-enterostomy should be performed in this case too, and on January 2 this was done. The stomach was found to be very thin-walled and dilated, and no evidence of fresh ulceration was discovered, but the pylorus was small and bound down by adhesions. An anterior gastro-enterostomy was done by simple suturing, and extra care was taken, owing to the extreme dilatation of the stomach, to attach the jejunum at extra points to the stomach so as to avoid any possibility of kinking. The patient did well for a few days and then that symptom, dreaded by surgeons in these cases—vomiting of bile and the contents of the duodenum—supervened, indicating the establishment of the "vicious circle."

This means that the duodenal contents instead of passing along the jejunum, as they should, regurgitate through the anastomotic opening into the stomach. If this condition persists the patient soon sinks from inanition. As the vomiting continued in spite of all treatment, and the patient was evidently going down hill, the abdomen was re-opened on January 16, and an anastomosis by simple suturing was made between the afferent and efferent portions of the jejunum. This second operation was at once followed by relief of the symptoms and the patient was soon taking ordinary food. Convalescence was delayed by a stitch abscess.

Dr. Frank Nankivell reports the patient to be now very well, going out to tea, to church, &c., and in great spirits. He also says that the trouble with her gums, which has distressed her for some years, and which prevented her wearing her teeth, has quite gone.

Experience is showing us that the operation of election for nearly all non-malignant diseases of the stomach requiring operation is a gastro-enterostomy. Pyloroplasty

is being gradually abandoned, and gastrolysis, by which is meant the freeing of adhesions about the region of the pylorus, gall-bladder and head of pancreas, is now said by its originator to be rarely sufficient *per se*, but should be combined with a gastro-enterostomy.

There is still some difference of opinion as to whether the opening should be made in the stomach anteriorly or posteriorly; there are advantages and disadvantages in both methods, but the posterior route seems to have the greater number of adherents. It has been my practice to do the anterior operation, with suturing of the jejunum to the stomach at additional points on each side of the anastomosis, and by this means I have hitherto avoided the "vicious circle." I have never used any form of bobbin or button, preferring simple suturing.

One may conclude by suggesting that surgical treatment is of primary value in chronic gastric ulcer and its sequelæ, and here its results are sometimes very remarkable; its next place would be in the treatment of perforation, and, lastly, it may be needed rarely in certain cases of simple ulcer and hæmorrhage from gastric ulcer.

Dr. E. B. ROCHE said that the question of pain was one of the most difficult questions they had to face. What were the cases in which it could be decided that there was an ulcer, and an ulcer of a serious and dangerous character, calling for operation? Whether they were justified in operating in any cases where perforation had not taken place was another matter of importance. Many years ago a young surgeon in Norwich held very advanced views and talked of this operation for a perforating ulcer, which had been seldom performed at that time. A young woman living near his (the speaker's) house was apparently in good health, and she had had no pain of any severity or continuousness. There was no suspicion of ulceration, and she was not under medical treatment. She came home one afternoon and ate a very liberal tea with great enjoyment, including, among other things, currant cake. Then, intending to go out and spend the evening, she bent down to button her boots, and while doing so she was subject to very sudden and severe pain; that pain increased violently, there

was evidence of danger, and this young surgeon was sent for. He came to the conclusion that, whatever might have been the antecedent conditions, she had become the subject of a rupture or of a perforation of the stomach, and he determined then and there to put his theory into practice. He opened the body and found a perforation of the stomach. Her tea—the currants and other things—was, generally, in the peritoneal cavity. He washed the peritoneum out thoroughly, and stitched up the perforation, and the patient made an excellent recovery and had continued in good health ever since. The point of importance there was that she had no previous pain, and yet there was an ulcer.

Mr. DUDLEY WRIGHT said that the first points which Mr. Knox Shaw had mentioned, namely, the difficulty in diagnosis and the necessity for examining the contents of the stomach, and doing everything that is possible before resorting to operation, were certainly very important ones. He congratulated Mr. Knox Shaw on the successful result of his case. It was not always that a second operation was successful, because the patient had often gone too far and there was a tendency to postpone further operation a little too long in the hope that things may right themselves. Mr. Knox Shaw had put it forward that they should not be too ready to operate in cases which showed a few symptoms of gastric ulcer or gastric neurasthenia. The speaker considered this a correct attitude up to a certain point, but at the same time they very often had to look at this matter from the point of view of expediency. He was bound to say that when they came across patients who had been suffering for years with their stomach, and in whom they had any reason to suspect that there was a certain amount of dilatation, and more particularly in cases where there were small relapsing ulcers in the stomach, as in the chronic catarrhal cases of cooks and kitchen-maids, and people of that class, he thought they were justified in performing gastroenterostomy. His own practice had been in that direction, and the extremely striking results he got—the immediate relief from all pain, the power of the patient to go back to do work under circumstances which were impossible before—impressed him with the fact that this operation was certainly a very justifiable one in such cases. Even in cases of neurasthenia, where there was a certain amount of atony of the stomach, with very little prospect, owing to the patient's circumstances or frame of mind, of getting much better from the neurasthenic trouble, he should say that gastroenterostomy was perfectly justifiable and extremely useful, more particularly in those cases where they had reason to suspect

small relapsing ulcers in the fundus of the stomach. Loretta's operation might be useful in a very few cases, and one occurred to him some years ago. A young woman was dying of cancer of the pancreas, which had invaded the pyloric region and encircled it and caused stenosis of the pylorus. She was constantly vomiting and was absolutely unable to take any food, and her life for the short time she had to live was made an absolute misery to her. He and Dr. Macnish decided that an exploratory operation should be done. He opened the abdomen and the stomach and dilated the pylorus with his fingers, with the result that the patient, for the last month or two of her life, lived with comparative ease so far as her stomach was concerned. He had performed gastro-enterostomy several times, but he had never done the anterior operation. It was ungainly-looking in the first place, and it had always struck him that a long loop of intestine brought up in front of the omentum must be always a source of danger. The operation from behind was extremely simple, and was rapidly done without any complications at all. He mostly used a Murphy's button, and only two cases had gone wrong with it, and in neither case could he satisfy himself that it was due to the button. The other cases had all done well, and in three of them the Murphy's button, to his knowledge and the patient's knowledge, had not been passed at all; what had become of it he did not know. He was speaking of cases where there had been not only simple ulcer, but cases which were otherwise inoperable cases of cancer of the pylorus. He had once used a Robson's bobbin, but he did not care for it and should not use it again. In his last two cases he had used the ordinary suture without a button at all, and the result was just as good, though it was a little longer operation. If other things were in favour of it, he preferred using the Murphy's button. A very short time ago he was called out in the middle of the night to see a patient—a child of about fourteen, who was in bed practically unconscious and in a delirious state. She had been ill for about a week with what appeared to be an ordinary cold, and about 6 o'clock that night she complained of some pain in the stomach, and had vomited slightly. Later, the pain became very acute in the stomach region, and she was wandering. There was some slight tenderness over the stomach region. There were three doctors there. One said he was quite certain she had a perforation of the stomach, he (Mr. Dudley Wright) did not see any reason for operating at all, and the third doctor, who was really in charge, was still more strong on the point that no operation should be done; so they decided not to

operate. The patient died within about three hours, and on the following day they had a *post mortem*. The stomach was as thin as they could possibly imagine any hollow viscus to be, and it was torn from one end to the other just as though it had been a piece of wet blotting paper. That was a case in which there had been absolutely no history of previous stomach trouble, although the child had a reputation in the family for gobbling her food and swallowing it down very rapidly. There was not a sign of peritonitis, and there was simply a little fluid, coffee-ground colour, in the peritoneal cavity. Death had occurred too early for the ordinary signs of peritonitis to develop.

Dr. H. NANKIVELL said he had sent up the patient in question to Mr. Knox Shaw, and he was very much struck at the time with his pyloroplastic operation; it seemed so extremely neat and easy that he thought he could have done it himself! It was to be regretted that the permanence of relief by this special operation in experience left much to be desired. He remembered one case of duodenal ulcer in which there was a great deal of pain. The case they had heard so much about that night always had pain at the cardiac end of the stomach, and not at all near the pylorus. He did not fancy that the pain frequently indicated the position of the ulcer, and, as apparently an ulcer might exist without any pain at all, it was no doubt a misleading symptom, either positively or negatively.

Dr. HAWKES (from the chair), in thanking Mr. Knox Shaw for his paper, said he quite agreed that it was the painless cases which were the dangerous ones. Any of them who had had to operate for ulcer of the stomach would admit that exploratory incisions could not do very much harm, and might do a great deal of good.

Mr. KNOX SHAW, in reply, did not think it was wise to excise a bleeding gastric ulcer; it must be very rare indeed that they would have to operate for acute hæmorrhage; those cases very rarely died, and, practically, in the majority of instances, they recovered. But one need not look for dilatation of the stomach before advising a patient to submit to gastroenterostomy. It was remarkable how gastroenterostomy would relieve the pain of a chronic gastric ulcer. They often got an obstinate gastric ulcer to heal, which would resist such treatment as rest in bed and diet, by doing a well-timed gastroenterostomy. He, personally, had seen some very striking results follow in neurasthenic cases, where there had been considerable atony in the stomach. One of the earliest cases he had seen was a young man who was

thought to have gall-stones. He had been treated for gall-stones by several good men, too, and he was sent to him to remove the gall-stones. He fell into the same diagnostic trap, and operated. There was not a single gall-stone; the gall-bladder was absolutely empty, but he found a number of adhesions. Then, in the innocence of his heart, he divided these adhesions and tacked a piece of the omentum round. He was rather proud of this, as he thought he had cured the patient; but an old college friend of his said "That case will come back to you again; you should have done gastroenterostomy." Some time after he heard that the man had died. All the symptoms had come back again, and he was taken to a hospital in the North of London and there operated upon, and he died very shortly after.

AN INTRODUCTION TO THE STUDY OF ANTERIOR COLPOTOMY AND COLPORRHAPHY.¹

BY WM. CASH REED, M.D., C.M.EDIN.,

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I ONLY realised three weeks ago that this evening's paper depended upon myself. I had hoped this session to be allowed to content myself with sitting at the feet of other teachers. It was not, however, a purely lazy attitude which I proposed to adopt, at least not for any length of time, for I intended to put into shape some matter concerning the subject of this paper and to submit it in a more matured state to the Society early next session. But our Secretary willed otherwise, and would take no denial. Hence I beg you to accept this short paper merely as an introduction to a big subject which I hope to enlarge upon next session in a paper more worthy of your consideration.

It is now some years since I spent a holiday, so to speak, in Berlin, with the object of acquiring the technique of some operations for which Professor Martin had become famous. That known as anterior colpotomy claimed special

¹ Presented to the Liverpool Branch, May 10, 1906.

attention, and it is this, with the minor operation of colporrhaphy, which I propose to describe.

It was not immediately, nor was it indeed for a long time afterwards, that it became obvious to me that this method presented conspicuous advantages, in many cases of pelvic mischief, over and above those which attend the more familiar and time-honoured operation of *cœliotomy* or abdominal section. I hope to show, however, that in a certain class of cases, the range of which is not very restricted, colpotomy in the sense in which I use it offers very great advantages to abdominal section.

With regard to colporrhaphy, let me at the moment merely state that as the greater contains the less, so colpotomy embraces the lesser colporrhaphy, which is merely a stage of the former, and may be classed as a minor operation, inasmuch as in it the peritoneum is not opened.

Colpotomy means, of course, cutting into the vagina. Its object in this case is to deal with the pelvic contents. The position of the cut is along the anterior vaginal wall, and its direction is vertical, not horizontal. This latter point is the crux of Martin's operation. It is but fair, however, to state that this operation originated with Dührssen, of Berlin, and was subsequently adopted by Martin.

THE OPERATION.

The patient, for a day or two beforehand, is treated with antiseptic tampons. I generally use ichthyol glycerine, in the proportion of one part of the former to eight of the latter. An aperient is given the night before, with copious enemata just before the operation. If there is any cardiac weakness, and in some cases of neurasthenia, it is well to give $\frac{1}{100}$ grain of strychnine hypodermically for a day or two prior to surgical interference.

The patient is placed in the lithotomy position and Clover's crutch adjusted with the circlet of leather *below* the knee, not above, as one so constantly sees done in error. The vulva and adjacent parts are now washed with soap and water and even lightly scrubbed with a nail brush. It is best to have had the parts shaved, or at least denuded of

hair by scissors. As to the soap, everyone probably has his own pet kind, else how can one explain the immense variety of surgical soaps on the market. Personally, being addicted to simplicity, I always use some old-fashioned grandmother's soap, preferably that containing a good proportion of turpentine. If it happens to be at hand the pure soft soap of the Pharmacopœia is excellent. Having washed off the lather, and seen especially to the cleansing of the vestibule, I now irrigate the vagina with hot sterilised water. I would draw attention specially to the cleansing of the vestibule, for if any septic matter be retained there, it is almost sure to be carried into the bladder in the course of operation, or afterwards on the end of a catheter. I mention the former because it is often desirable to use the catheter whilst operating to ascertain the limitations of the bladder, or to make quite sure it has escaped injury.

Now adjust a weighted speculum—we use Auvard's—seize the anterior lip of cervix with a uterine hook which has a long handle. Dilate the uterus, after first ascertaining its exact position and size with a sound, by means of Heger's or other dilators. Personally, I like nothing better than to commence with fine ordinary silver urethral bougies, and when the canal is sufficiently patent to continue stretching, by means of silver uterine dilators. May I lay stress on *stretching* as distinguished from tearing. Nothing is easier than to tear. It requires time and patience to dilate. I have learned that the key to the latter is to have the dilators steeped in boiling water. The uterus yields readily to the combined stimulus of heat and pressure. There is no need whatever to use vaseline or any kind of grease, which is only messy and obscures one's view.

When the uterus is sufficiently dilated use the curette freely, finally washing away *débris* with a current of water through a pipette. The water and the pipette are used throughout the operation. The latter is held at one side of and above the vulva, and the water flows from it just sufficiently to keep the field of operation clear of blood. Perchloride of iron tincture may now be thrown into the uterine cavity, about 20 minims by means of a syringe, but the force of this injection must be very gentle.

What is known as Martin's hook-sound is now introduced and locked in the manner described. In point of fact this instrument was invented by Dr. Orthmann, Professor Martin's assistant at the time I speak of, to meet the exigencies of the case, and without it it would be almost impossible to carry through the procedure.

A uterine hook now grasps firmly the anterior vaginal wall about half an inch below the meatus urinarius. This hook is pulled up vertically by an assistant and steadied, whilst at the same moment the handle of the hook-sound is depressed by a second assistant. The result is that a long ridge of mucous membrane from the meatus to the cervix is put on the stretch and stands out more or less in relief. It is well to reassure oneself at this stage by calling to mind that the little manœuvre described has *really* had the effect of drawing the mucous membrane away from the bladder beneath. In point of fact it emphasises the depth of the bladder from the surface. It might otherwise seem as though the bladder itself were drawn forward, and that this proceeding was the most likely one to ensure its being wounded beyond the shadow of a doubt.

An incision is now made from the hook to the termination of the mucous membrane at the cervix. As to the safe depth of this incision, it is impossible to fix any rule. In persons who have borne many children the mucous membrane is often very thick, perhaps one-sixth of an inch. In other and attenuated patients it is often very much thinner. The two sides of this vertical incision are now further separated from one another and from the cellular tissue beneath. This is best done, I think, with the finger-nail whilst the cut edge of the mucous membrane is held forwards and outwards by a pair of dressing forceps. As one approaches the cervix there are pretty strong bands attaching the mucous membrane to the latter; these may be divided with scissors. The bladder is now generally in full view, and is to be gently eased off the body of the uterus by the finger, slowly, steadily and persistently. Eventually it is tucked under the symphysis pubis. When there it is retained in that position by a retractor. Now by

carefully depressing the handle of the hook sound the fundus uteri may be felt, if it cannot be seen, and the vesico-uterine fold of peritoneum comes into view.

This structure is generally described in text-books by some such terms as these—"glistening," "a pellucid structure," with a "little fluid to be seen through its two layers," and so on. I cannot say that Nature has been kind enough to demonstrate it with such precision in my cases, but as there can be nothing else than this structure at this stage of operation preventing one's finger entering the pelvic cavity, I have cut on, and eventually through the barrier, which presented itself. Perhaps nothing special occurs after this incision is made, perhaps a Fallopian tube or piece of mesentery appears at the wound. The upper edges of the peritoneal cut should be caught by a Spencer-Wells forceps, and I may add that it is important not to make the cut itself too extensive laterally.

Now remove the hook-sound and grasp the uterus with a hook about the junction of the fundus and body. Then place another hook further on towards the fundus, and if necessary a third even, and exercise gentle traction forwards and downwards. It depends mainly upon the bulk of the uterus and the density and extent of inflammatory adhesions how soon the uterus will yield and appear outside the vulva. The adhesions referred to are broken down gradually, always with the finger. When the uterus becomes procident the ovaries and tubes on either side will accompany it, lying at a slightly higher level. This is not, of course, their normal position, but is explained by the fact that we are now looking at the *under*, not the upper, uterine surface.

The operation is now continued to such an extent as may be necessary; ovaries may be ligated and removed, the same may be said of the tubes, one or both, and if a fibroid is visible it can be removed, and finally, if the uterus is malignant or chronic metritis be advanced to an extent which is incurable, the whole organ may be excised.

Whatever then may have proved essential having been accomplished, the cervix is again caught by forceps and the

fundus is pressed upon. Now a kind of cradle-rocking takes place, the movement *à bascule*, as the French call an allied movement, when the uterus slips back into the pelvic cavity. The long vaginal cut has now to be repaired, and this is done in two stages. The first consists in stitching the cut edges at the greatest depth to the body, not the fundus, of the uterus, including in this ligature both upper and lower edge of peritoneum. Two stitches should be employed to effect this. Now two more should be fixed into the cervix, involving the cut edges of the vagina on either side at the same time. The second stage consists in making a running continuous suture of thinner catgut along the whole length of the cut with accurate apposition of its edges. The whole wound now looks very neat. The vagina is lightly packed with cyanide gauze with the object mainly of assisting to support the uterus. A T-bandage is finally adjusted and the patient removed to bed.

The subsequent treatment is simplicity itself. The gauze is removed the second day and probably it will be quite unnecessary to apply any further dressing, or even to employ any douching. The patient generally passes water naturally in the course of a few hours. It is best, I think, to elevate the foot of the bed with blocks of about six inches, just as is done in cases of vaginal hysterectomy by the ordinary method. Thus the pressure on the severed peritoneum is reduced to a minimum. I ought to have said no drainage whatever is necessary. The patient is up in between two and three weeks.

Thus, gentlemen, I have endeavoured to describe the operation known as anterior colpotomy. I now come to say a few words upon anterior colporrhaphy.

Anterior colporrhaphy, or suture of vagina, is performed sometimes for the cure of cystocele, but chiefly for the fixation in a normal position of a retroflexed or retroverted uterus. The earlier steps of the operation are exactly those of the one described, but in colporrhaphy one stops short of opening the peritoneum, in fact, a stage or two before this membrane is reached. The bladder is freely stripped from the cervix and uterine body, but not quite to the same

extent as formerly described. When the uterine body is freely exposed thick sutures are placed so as to include the cut in the mucous membrane on either side and to transfix deeply the uterine body. Then the long and thinner thread before described is used to adjust the rest of the cut raw surface throughout its whole length. The after-treatment is the same in each case. As the two thick sutures referred to above are drawn tight it is beautiful to observe how the retroflexed or retroverted uterus assumes the normal ante-flexed position. I must confess, however, that I do not quite understand why the mucous membrane of the anterior vaginal wall should be competent to sustain in the right position a hitherto tilted back uterus. Yet it does so. The explanation is, in part, doubtless to be found in the fact that the utero-sacral ligaments which support the uterus are still intact and are competent to perform their function. One other point is interesting and significant in this connection, and throws a side light on the situation, viz., that a prolapsed uterus (and retroversion is the first stage of prolapse), comes down secondarily to the bladder and rectum, notably the former. At least so I think, and the remark is based upon a frequent observation made in the course of pelvic operations when the patient is in the lithotomy position and under an anæsthetic. When the patient strains in an early stage of anæsthesia or in coughing or vomiting, the stress of pelvic pressure is spent first of all on the bladder and the rectum, and these prolapse first and foremost. This is an everyday observation, and I have often pointed it out to medical friends assisting. So definite is this result of straining that it is of no uncommon frequency for the os uteri, which has hitherto been clearly visible, to become covered up and completely hidden by prolapse of the bladder in front and of the rectum behind. In short, of the three viscera the uterus is the last to descend. The anterior wall divided in the operation would, of course, contract in healing and form a firm scar, thus hindering cystocele. Thus with the cure of the latter and a firm point *d'appui* for the uterine body at the point of its attachment to the vagina, the uterus is less competent to revert to

its abnormal position. These remarks I throw out at all events as the explanation.

I would refer now very briefly to three points :—

(1) Certain individual cases which have undergone operation, and in which marked success has followed its adoption.

(2) Secondary hæmorrhage occurred in one case, due to venous oozing. It was checked by tamponade, &c.

(3) The advantages of the operation consist chiefly in (*a*) absence of shock ; (*β*) clear field of operation.

(4) As regards pregnancy, the crux of the operation is in fixing the body and not the fundus of the uterus.

Finally, gentlemen, I did not think it within the scope of this short sketch to attempt to deal with the details of each further procedure after the peritoneum was opened, for to do so would be to try and cover the ground practically of all pelvic diseases, a feat manifestly impossible within the scope of this essay.

I would merely remark with regard to diseases of the Fallopian tubes, that their appearance, character and pathology vary immensely, *e.g.* :—

(1) Sausage-shaped, as in tubercle.

(2) Pea-pod, due to irregular cicatrical contraction.

(3) Dilated, which lend themselves to plastic operations.

(4) Stenosed, caused by the gonococcus, just as the gonococcus causes stenosis of the male urethra.

ON CHRONIC NEURASTHENIA, AND
ITS RELATION TO THE DISEASES OF WOMEN.¹

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COULD we but see in a panoramic view the accumulated losses the world has sustained at the hands of neurasthenia, how genius has been crippled and its gifts to men attenuated, how the fount of morals has been defiled, the output of the original thinker arrested, the researches of the man of science summarily shut down, we might fitly conclude that the wastage of neurasthenia has cost the world as much as the ghastly ravages of war.

Nay, more, for to the arts and issues of war we owe, not only many useful inventions and discoveries, but, as Draper well emphasises, much of the progress of mankind. No such mitigating plea can be laid to the credit of neurasthenia; in all its dismal history it has been a bane to civilisation, an incubus on human progress, a physical scourge to humanity.

The great, wise, and eminent, as well as the mass of mankind, have alike paid heavy toll to this evil genius of the race. If you seek concrete instances to point the moral and adorn the tale, they lie almost as thick as leaves in Vallom-

¹ Presented to the Section of General Medicine and Pathology, June 7, 1906.

² This paper was illustrated by a series of lantern slides, sphygmographic tracings, respiratory curves, &c., prepared by the authors. Various considerations prevent their full reproduction here: later they may probably be published in their entirety.

brosa. Here is a brief list selected from eminent men in the Victorian era. Charles Darwin, when residing at Down, could only work, as a rule, some three hours a day. "For forty years," says his biographer, "he never knew one day of the health of ordinary men." Insomnia, dyspepsia, and nervous prostration were the trinity of furies that attended him.

Huxley is revealed in his biography in similar wise. "Headache, headache," was his perpetual *bête noir*. Mental depression was pretty nearly as constant, as he vividly puts it on one occasion, "Slept better than usual, and awoke without blue devils for the first time for a week." Here is a fragment given by his son: "He would come in thoroughly used up after lecturing twice on the same day, and lie uneasily on one sofa, while his wife, whose health was wretched, matched him on the other. Yet he would go down to a lecture, feeling utterly unable to deliver it, but once started, carry it through successfully; at what cost of nervous energy was known only to those at home."

But from a quite unanticipated source comes a description of a typical neurasthenic attack, and the personality is no other than John Stuart Mill. Here is his narrative: "I was in a dull state of nerves, such as everybody is occasionally liable to—insusceptible to enjoyment or pleasurable excitement." Then follow some mental perturbations, and as a result: "At first I hoped that the cloud would pass away of itself, but it did not. A night's sleep, the sovereign remedy for the smaller vexations of life, had no effect on it. I awoke to a renewed consciousness of the woful fact. I carried it with me into all companies, all occupations. Hardly anything had power to cause even a few minutes' oblivion of it."

"During this time I was not incapable of my usual occupations. I went on with them mechanically, by mere force of habit. I frequently asked myself if I could or was bound to go on living, when life must be passed in this manner. I generally answered to myself that I did not think I could possibly bear it beyond a year. When, however, not more than half that time had elapsed, a

small ray of light broke in upon my gloom." "Thus the cloud gradually drew off, and I again enjoyed life, and though I had several relapses, some of which lasted many months, I never again was as miserable as I had been."

What the world has lost in sterilised literary years, in blocked and intermittent scientific work, from the enforced paralysis of its able men, can only be faintly adumbrated by this occasional raising of the curtain of private life.

So much for the incubus of neurasthenia on genius. Like the old man of the sea, it is relentless in its tyranny over its victims. Like *pallida mors*, it knocks alike at the doors of the rank and file as at those of the gifted and brilliant.

What, then, of the rank and file? I hold firmly that the historic persistence of a people is largely determined by the normal physical vigour of the proletariat. Further, that on this rock—the decadent health of the common people—every prior civilisation has hitherto struck.

Are *οι πολλοι* then free from neurasthenic decadence? So far from this, the stress of neurasthenia on the mass of mankind is as detrimental as on the leaders. This neural defect underlies much of the chronic disablement of vast numbers of the common people. Consider the universal diffusion of the chronic diseases of women, and that most of the ill-health accompanying these is purely neurasthenic in type. Consider the enormous diffusion of chronic ocular defects where neurasthenia figures scarcely less often as cause than as result. Consider, further, the wide incidence of dyspepsia where the nutrition of the nervous centres is cribbed, cabined, and confined, and one can easily trace the widely-distributed influence of this upas tree, permeating civilisation with its baleful miasm. Estimating, then, the quantitative debasement of the nervous currency due to neurasthenia in the proletariat, and the qualitative spoiling of capacity among the makers of history and the leaders of progress, we must conclude that the ravages of war and their cost to the community are equalled, nay distanced, by the spoliation due to neurasthenia draining the commonwealth in the piping times of peace.

WHAT NEURASTHENIA IS NOT.

To-night our attention is to be confined to a clinical and therapeutic study of chronic neurasthenia, and especially as constitutional ally in the chronic diseases of women.

What, then, is neurasthenia, and how comes it bracketed with an apparently alien subject—the chronic diseases of women?

Just as before Duchenne various distinct diseases of the spinal cord were massed together as chronic myelitis, so until comparatively recent times neurasthenia was coupled with two or three cousins german, and the whole styled hysteria. For purposes of treatment this was a disastrous blunder; and, when the critical history of hysteria comes to be written, it will be found that this mistake in diagnosis has been responsible for almost as much cruelty—with the best possible intention—as vivisection. The retrospect is simply appalling.

For this baleful error there was less excuse, since neurasthenia was isolated as a definite clinical entity so long ago as 1755, by Whytt. The rehabilitation of it as a coherent body of symptoms was finally effected by Beard in 1879. Since then further research as embodied in literature has been very considerable and ever increasing, yet by some fatality until quite lately the work up to date has been ignored and no place found for it in most text-books.

“Strange,” says Savill (1899) “strange to say it is either not referred to at all or is very inadequately dealt with in the text-books in current use.”

OUR KNOWLEDGE OF NEURASTHENIA IS CLINICAL
KNOWLEDGE.

Neurasthenia has been isolated as a definite clinical entity, with diagnostic characteristics and with a clinical pathology.

I say a clinical pathology, for *post-mortem* pathology knows nothing of neurasthenia. There are no demonstrable tissue changes as the physical basis of this form of ill-health.

What, then, do we know of the pathology of neurasthenia?

Like some other nervous diseases, our knowledge of neurasthenic pathology has hitherto been obtained in most part by analogy and inference. Direct demonstration of the pathology underlying the clinical symptoms of neurasthenia is as yet as lacking as in epilepsy or chorea.

Within what circle, then, have we narrowed down our knowledge of neurasthenic pathology? Briefly, that the changes are probably in the molecular structure of the nerve protoplasm; that the changes are not sufficiently gross to materialise as changes of cell structure; that the centres chiefly affected are those governing the vaso-motor apparatus; that in a proportion of instances the pathology is that of autotoxis; that in chronic cases with heightened arteriole tension, autotoxis is probably always the pathological moiety of neurasthenia.

A CLINICAL SUMMARY OF NEURASTHENIA.

But as a definite clinical entity neurasthenia is demonstrable enough, though its pathological counterpart be elusive. As a definite clinical entity it is best studied in the pronounced cases.

These cases reveal neurasthenia to us

(1) *As a special form of irritable weakness of the nervous system, where heightened sensitiveness goes with defective power.*

(2) *As a generalised nerve deficiency, there being no part of the body that does not yield its quota to the tout ensemble.*

(3) *With distinctive features in different cases, in that in this case one part of the organism, and in that another, bears the chief incidence of the neurasthenic attack.*

But no more grievous mistake can be made than to regard the operation of neurasthenia on the human body as limited to the part mainly affected. Again I must insist that it is a generalised affection with certain organs picked out for the chiefest manifestations; all organs and tissues bear some tribute in the neurasthenic. Another pitfall is to look upon the organ last affected, or the last insistent symptom, as representing the total disease. Far from it.

Here is an illustrative case: A young lady, whose whole life since adolescence had been a chronic martyrdom, was sent to me with floodings at the period, and with acute pain. Remedies taken over terms of years, change of residence and curettings proving of no avail, removal of the appendages was advised to arrest the hæmorrhage and banish the periodic pain. Ere this was done she passed into the hands of an eminent semi-homœopath, who for some months did his best, with no more success than mine. He then referred the lady to me for operation. This I carried out, removing the appendages, finally arresting the hæmorrhage and eliminating the stressful effects of the pain.

Mark the issue. The gastric condition, always troublesome, but never insistent, now assumed the chief rôle. Vomiting with gastralgia took the place of the uterine symptoms, and the patient succumbed in a few months in a South of England watering place to marasmus, all efforts to adequately feed by the stomach proving unavailing. The pelvic organs being removed from the sphere of influence, the alimentary tract was now the chief incidence of the generalised neurasthenic taint.

This was several years ago, and I have learned much of neurasthenia since then.

So much by way of a summary of the clinical and pathological essentials of neurasthenia.

HOW IS NEURASTHENIA RELATED TO THE DISEASES OF WOMEN?

What is the unholy alliance between neurasthenia, which is a generalised functional nerve defect, and the chronic diseases of women, which correspond to a localised organic defect? What does gynæcology in this galley? Now, here a little auto-biographical matter may not be uninteresting.

I. In my earlier gynæcological days I have seen hundreds of cases, where pelvic disease was the prominent factor, treated as though the rectification of the local pelvic defect carried in its train the bodily return to health. Very

often, however, even after the local condition had been rectified, the generalised ill-health remained obstinate. Prolonged observation of these cases induced me to coin a formula that in operative cases the patients mostly recovered from the operation.

II. My next stage was developed when in my early consulting days the responsibility was transferred to myself. In many cases where pelvic ill-health had led the way, but where its symptoms were now compounded with chronic invalidism, creeping on in the train of the pelvic affection, the assurance I gave myself, and others, was that when the original pelvic trouble was removed, the local state thoroughly righted, the super-induced constitutional ill-health would naturally follow suit, and forthwith dwindle and disappear. Alas for such views! too often the expectation was a dismal *non sequitur*, and the patient refused to be comforted by the assurance that as the cause was removed, the effects must vanish. Often these did nothing of the kind.

III. The next stage was marked by the choice of a working hypothesis—that of uterine reflexes. There *must* be some connecting link between primary pelvic disease and that of general ill-health almost always bound up with it. And the amazing celerity with which distant symptoms sometimes came and went with the coming and going of the pelvic affection lent support to the view. Of such was the sickness of pregnancy; the mammary ache and pain, often acute, waxing and waning with the period; the mental perturbations, sometimes blown away like a cloud when the pelvic defect was rectified. *Ex uno disce omnes*: and thus the distant symptoms developed in the train of pelvic affections, the headache, the eye strain, the gastric deficiency, the general debility, the heart disturbance—these by hasty generalisation were, and often are, still viewed as reflex from utero-ovarian affections, coming when these came and disappearing as these disappeared. But the dry light of facts will allow no such view. The uterus and ovaries may be diligently tinkered, nay, even removed; but the general health often continues as bad, or

even worse. Again, the same generalised ill-health frequently exists with no utero-ovarian affection at all; or, again, well-marked pelvic affections may, and do, commonly occur with no so-called "reflex" disturbance whatever.

Obviously, then, so casual a hypothesis as that of uterine reflexes would not fit the facts.

IV. But the solution of the problem was stumbled upon almost by accident. For quite other purposes I had made a careful and elaborate study of certain classics on neurasthenia. This, however, was but text-book work. When I turned from the library to the laboratory, and left text-books for hospital ward work, the amazing similarity between many of the verified symptoms of neurasthenia and the generalised ill-health of my gynæcological patients confronted me.

I had had an analysis of 100 cases of utero-ovarian disease made, relative to what affections of other organs accompanied these cases. And most frequently occurring symptoms in my list—gastric, cardiac, and cerebral symptoms—were precisely corresponding to the more frequent clinical types of neurasthenia.

And now the whole evidence began to accumulate *en masse*. There was the fact, as Weir Mitchell pointedly puts it, that sooner or later in the history of a neurasthenic the question of uterine therapeutics comes up for consideration. There was the fact that the most typical cases of neurasthenia were to be found in women with a long prior history of uterine symptoms. There was the neurasthenic halt, in the early years of puberty, due to the impact of new functions on an immature organism. There was the neurasthenia often seen in urban life produced by rapidly succeeding pregnancies. There was the characteristic neurasthenic melancholia, often observed at the menopause. And thus the evidence of the reproductive life as a most frequent cause of neurasthenia became clear.

Thus was evolved the thesis which I present to you to-night with all the pride of an original observer, that the generalised ill-health concurrent with pelvic disease is as a rule of pure neurasthenic type, and the complement of this

is also true, that utero-ovarian disease is a prolific cause of neurasthenia in women.

THE CLINICAL HISTORY OF NEURASTHENIA. A COMMON TYPE.

Let us now investigate the personality of neurasthenia a little more searchingly. It is a multiple personality; but, unlike that of Dr. Jekyll and Mr. Hyde, its personal equation is uniformly mischievous. Here is an average type. A married lady, whose adolescent health has been fair, but not exuberant, has several children in rapid succession. The last leaves her with a consciousness of being played out, and this limited health persists, only temporarily benefited by a summer holiday, or a prolonged absence from home. The periods are free, with a troublesome leucorrhœa, and a haunting backache. Local examination, possibly some years after the last baby, reveals a bulky displaced uterus, with patches of cervical catarrh.

If the examination be made by an expert, one or both ovaries are discovered also prolapsed, and the whole pelvic floor found to be a mass of limp tissues, descending on the least strain. The clinical history is reviewed, and the *fons et origo* run to earth. It is obviously the uterus and all its works that are at fault; and the organ is straightened by the inevitable sound, and pessaries of sorts introduced. Rest is now insisted on; but, leaving out some fluctuating improvement, only tardy progress is made. The periods are still profuse, and the physician, a little perturbed, hails this as the keynote of the defective health. The uterus is curetted, various promises being held out as to the benefit undoubtedly to follow. Time passes, and the general health remains very much *in statu quo*. Changes now possibly occur in professional advisers; it is fortunate for the lady if she escapes the net of Christian Science, or keeps her uterine appendages out of the hands of the surgeon. Meanwhile, the constitutional health continues to drift, and the patient has different relays of symptoms at almost every visit. Her sleep is defective and dreamful; her nerves bear neither loud sound nor heavy footfall; her powers of endur-

ance, alike of mind and body, are wofully lessened. Add to these whatever of gastric or cardiac troubles supervene—and there are always some—together with her original pelvic ailments, and of this patient it may truly be said that there is no health in her.

This, however, is not all. Pelion is now piled upon Ossa. The same error of judgment which allowed all this woful category to supervene now seeks by heroic measures to eliminate it. The pelvic organs, head and front of the offending, are ablated with the hope that now the stress of these disturbing functions is removed the bodily condition may self rectify. But if active measures end here—and they too often do—nothing of the kind happens, the patient may go from bad to worse; for to the generalised neurasthenia before operation has been added the increased neurasthenic stress due to the impact of operation on an enfeebled body.

AFFIRMATIVES AND NEGATIVES.

I have put the neurasthenic *tout ensemble* in a concrete form, that I may further emphasise the true views as well as the common errors attaching to neurasthenia and its frequent treatment.

(1) To consider the pelvic troubles in such a case as the primary cause of the whole ill-health—that is right; but to regard the constitutional condition as still controlled by the existing pelvic defect—that is wrong. The constitutional ill-health has passed out of the pelvic bondage, and is now a lesion in and by itself requiring constitutional treatment.

(2) To remove the primary cause, that of pelvic disease, which has precipitated wider issues than itself—that is right; to expect that the distant clinical symptoms will self rectify thereupon—that is wrong. The primary cause acts as an embargo on progress, and requires removal; but the mere removal of one local defect does not remedy the residual neurasthenic defects.

(3) After the primary causes have been remedied, and the portal by which neurasthenia entered duly closed, to pick out this and the other insistent symptom—to-day

cardiac, to-morrow gastric, next week mental—for sole treatment—that is wrong. To recognise the whole condition, past and present, as a clinical whole—to avoid the temptation to regard the latest or the most insistent symptom as monopolising treatment—that is right; for none other than a truly scientific review of the facts of the case, past and present (that is the totality of symptoms), will allow of cure. It may be patched—there are several ways of patching it—but patchwork is not cure.

NEURASTHENIA A GENERALISED AFFECTION.

Various arbitrary subdivisions of neurasthenia have been proposed, mainly to allow of easier clinical study. I present to you the broad view that neurasthenia is a generalised bodily defect, to which every organ and tissue contribute their quota, but with especially frequent stress on the cardiac, gastro-alimentary, and pelvic organs, the special senses and the intellectual centres. Now one and now another of these organic areas has the stress of neurasthenia chiefest, and thus pelvic, cerebral, or cardiac symptoms arise which overshadow the others and characterise the case.

THE SYMPTOM-DETAIL.

I do not intend to enumerate the protean symptoms which neurasthenia may evoke. The list of detail is an important one, and I regret I can only deal with a short selection. Leading the way comes *the generalised loss of flesh*, the attenuated frame which is so pronounced in many cases; firstly, this appears as the issue of neurasthenia, and, secondly, tends undoubtedly to its perpetuation. It is one of the first conditions that needs rectification in the treatment of the state.

Next comes a series of *abdominal objective changes*, e.g., ptosis of the kidneys, chiefly the right; hyperchlorhydria and dilatation of the stomach; a superficial aortic pulsation, sometimes taken for aneurysm; and the various ptoses, or gravitations of the abdominal viscera: e.g., renal ptosis, dropping of the stomach, the liver, the intestine. What do these

SPHYGMOGRAMS IN NEURASTHENIA.

AVERAGE CASES.



Chief symptom, Spinal Pain.



Chief symptom, Dysmenorrhœa.



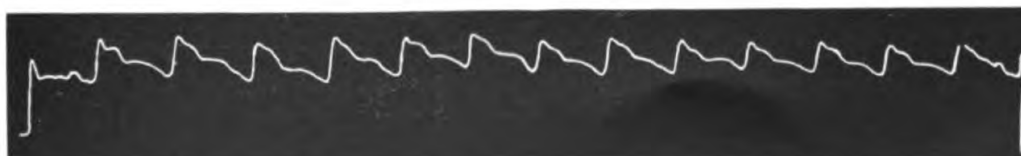
Chief symptom, Pelvic Pain.



Chief symptom, Insomnia.



Chief symptom, Dyspepsia.



Chief symptom, Brain Fag.

curious phenomena imply? Go a little further and note the ptoses of the uterus and ovaries; direct your attention to the limp and toneless state of the musculature of the pelvic floor; note the atonic and flaccid poverty of the abdominal walls, and you will see, in the loss of retentive power of the abdomen, in the tonelessness and floppiness of the supporting structures, at least a predisposing cause of abdominal ptosis. So important do I deem this element of abdominal atony in neurasthenia that I cannot hold any case with former abdominal symptoms as cured unless and until the parietal tone of the abdomen has been largely restored by Swedish exercises and similar means. To simply fix a prolapsed organ in such a case, as so many surgeons do, and leave matters there without ensuring the renewed tone of the parietal supporting structures, is to my mind but a patchwork procedure not worthy of the name of cure. No wonder that eminent surgeons, after their 1,000 cases of fixation for ptosis, find it an unsatisfactory procedure. As an isolated measure, could it be aught else? And I would also scarify the lax procedure of hiding the condition with belts—again patchwork—instead of dealing with the still persisting atony.

But to return to our muttons. The *circulatory phenomena* are numerous and various. By far the most frequent is tachycardia, rarely bradycardia, and the heart beats often run up some ten or twenty per minute after sitting up in bed twice or thrice in succession. Irregularity in rhythm and intermittency are common enough.

The vascular phenomena in particular are most interesting. And "right here" I should like to give the quietus to one of the numerous errors that are current in textbooks regarding neurasthenia. In a marked case of neurasthenia the skin is mottled, the extremities cold and the pulse small. These indications are rightly interpreted as those of heightened peripheral resistance; the smaller arteries are, so to speak, clamped down. But when Horsley goes further, maintaining that these are peripheral phenomena alone, deriding the notion that the circulation is weak, declaring that the heart is uninvolved, I can only

say the facts are against him. The pulse is in marked cases tachycardiac, dicrotic and frequently arrhythmic; what do these manifestations with an uninvolved cardiac muscle? Moreover, neurasthenia is a generalised disease radiating through all organs and tissues. Why should the cardiac musculature be exempt? Finally, how can an organ poorly nourished, and working against increased resistance, maintain its unimpaired tone? The statement is an inexact one; in typical cases not only is the arteriole resistance heightened, but the cardiac vigour is lessened.

Another error in connection with *the blood condition* here calls for notice. It has been assumed by observers that the anæmic state of skin and mucous membranes corresponds to a veritable anæmia or blood poverty, calling for the use of iron or other hæmatinic.

Weir-Mitchell himself lays stress on this and advises the use of lactate of iron in 7 gr. doses for some time. Now see how this works out in practice. I saw with Dr. Watkins, some years ago, a young lady with various clinical symptoms of neurasthenia, including dysmenorrhœa. Her pulse was a dicrotic pulse; the appearance of the skin and mucous membranes denoted a marked anæmic condition. She was ordered iron, chiefly as protoxalate; took it steadily for some weeks without the slightest apparent result from its use. A blood examination was now made, and to my surprise, the hæmoglobin richness and the red corpuscle ratio were very nearly normal. How, then, to account for the anæmic appearances? I had to consider the state as one of pseudo-anæmia, and latterly the term skin-anæmia has come into use to designate this condition of apparent, but not actual, blood poverty in neurasthenic cases.

Weir-Mitchell advocates the giving of iron as a routine measure in the therapy of neurasthenia, and, as most of these cases show outward and visible signs of anæmia, I was misled into following this practice. But one day I had another rude awakening. A patient with chronic and apparently inveterate neurasthenia, in whose case the appearance was that of moderate anæmia, showed on blood examination a hæmoglobin richness actually above the

normal! I now discarded the routine use of hæmatinics in these cases as not called for and therefore useless.

The symptom detail relating to gastric, cerebral and cerebro-spinal cases must be passed over.

THE CLINICAL RELATIONS OF NEURASTHENIA AND CHRONIC PELVIC DISEASE IN WOMEN.

Neurasthenia accompanies with especial frequency conditions of chronic pelvic disease in women. Five-sixths of the constitutional symptoms observed in the chronic diseases of women are of neurasthenic character.

It is highly important for purposes of treatment to define what clinical relation the pelvic symptoms bear to the neurasthenic state in a given case.

Briefly, this relation may be one of two alternatives:—

(1) *The pelvic symptoms may be part of the generalised neurasthenia, as typically neurasthenic as the headache, the gastralgia, the palpitation.* These neurasthenic pelvic symptoms may appear as neuralgia, menorrhagia, spasmodic dysmenorrhœa, coccygodynia, or leucorrhœa.

I am aware that in indicating these pelvic symptoms as occasionally of neurasthenic origin and character, I am going beyond the findings of neurasthenic specialists. These authorities, with discretion rather than valour, ignore entirely that unstable mass of organs, the female pelvis, as a possible area of neurasthenic manifestations. Why this bodily segment, with its wealth of vaso-motor and other sympathetic supply, should be ruled out of participation in the symptomatology, is, I say, difficult to justify. When every other part of the body may contribute its quota to the neurasthenic *tout ensemble*, there is no *a priori* reason for excluding the pelvis. And there is plenty of *a posteriori* evidence to show that certain pelvic symptoms may be purely neurasthenic symptoms. Take *spasmodic dysmenorrhœa* for instance. Here is a case:—

A young lady of some 24 years, with marked neurasthenic symptoms, including loss of weight, impaired digestion, headache, perspiration, anæmia, &c., had also excessive

and frequent periods, lasting sometimes for ten days, and actually recurring twice a month. Spasmodic dysmenorrhœa was co-existent. She was put on a surplus milk dietary, suitable therapeutic measures were instituted, and she was sent to recuperate at a high altitude in Switzerland. In six months, or less, she had gained ten pounds in weight, the erstwhile tired girl had performed very creditable feats of mountaineering, had entirely lost the spasmodic dysmenorrhœa, and the period, now only occurring once a month, and lasting but four days, came promptly up to time.

Here spasmodic dysmenorrhœa and menorrhagia alike disappeared with other classical neurasthenic symptoms under an anti-neurasthenic *regime*.

Here is another instance, still more dramatic. A young lady, scarcely over twenty, presented, beside the various classical symptoms of neurasthenia, two which stood out with especial prominence, spasmodic dysmenorrhœa and constipation. The dysmenorrhœa was so acute that she had to resort to $\frac{1}{2}$ -grain doses of morphia to quell the pain—a pretty prospect for a girl beginning life! She had for long been under excellent homœopathic treatment, with no material benefit. I thoroughly dilated the cervical canal, and applied the usual medicaments to the endometrium repeatedly. Result, very moderate benefit. I then sent her to Switzerland, to a high altitude; but as she spent her time in fashionable hotel life, and promenaded with the other fine ladies, the issues were also disappointing. (I did not know then, what I have since discovered, that profitable residence in Switzerland requires a well-planned routine, and mere residence is often fruitless.) But to return. The young lady came back practically *in statu quo*. Now I resolved on more stringent measures. I sent her to a first-class nursing home; kept her strictly in bed for six weeks; stopped her cigarette smoking and alcoholic beverages, and gave her the usual Weir-Mitchell treatment, plus Swedish exercises. The course was thoroughly carried out. Result, a period which, though still somewhat painful, was as moonlight unto sunlight compared with the fierce pangs of previous periods; no hypnotic was necessary; the recurring

monthly crisis was no longer a matter of dread. The constipation also practically vanished; when she came to us, the aperient dose was two drams of Kutnow's salts each alternate morning. When she left us no aperient was necessary.

So much for spasmodic dysmenorrhœa appearing as a neurasthenic symptom. I am not compiling a body of evidence, or the proofs could be indefinitely extended.

Menorrhagia.—To consider uterine hæmorrhage as a neurasthenic symptom in certain cases may occasion you, as it did me, some surprise; and yet the facts will bear no other interpretation. Moreover, hæmorrhage occurring as part of the neurasthenic *tout ensemble* is usually curable by neurasthenic constitutional treatment, and this is an important proof of its constitutional origin.

I have already cited the case of a young lady who, with copious periods lasting ten days, and recurring twice a month, was cured of her hæmorrhage, pain passing with other marked neurasthenic symptoms, during a four months' residence in Switzerland.

I was summoned to Paris to see a lady of a certain age, who, after the menopausal age, had a well-defined and characteristic neurasthenic breakdown. Great nervous tension, fits of depression, with tears, insomnia, and other constitutional conditions, marked the case. What alarmed the friends most was, at this menopausal age, the recurrence of pelvic pain and the return of hæmorrhage. I knew the lady well, was able to give her an explicit assurance of the benignant import of the condition, brought her over to England, where, under the care of Dr. Byres Moir and myself, she was given a thorough anti-neurasthenic scheme of treatment. She rapidly improved in general health, the hæmorrhage disappeared, and in about a couple of months she was able to cross the Atlantic. I saw her again two or three years after; she was in robust health and had had no return of the bleeding.

That hæmorrhage will appear under the stress of neurasthenic influences is within the experience of most. Some time ago I saw a lady in whom the menopause had existed

for some eighteen months. At this juncture she underwent a severe nervous strain, in the nursing and death of her husband, who succumbed to angina pectoris. Uterine hæmorrhage now set in, lasting some three weeks; it promptly yielded to remedies and did not return.

I am inclined to look on some cases of inveterate hæmorrhage as having a definite neurasthenic element in the causation, in that the bleeding yields to definite constitutional treatment on neurasthenic lines. Later, under the heading of mountain altitudes, I narrate a striking case. Here I may say that the way in which hæmorrhages are controlled by a sufficient and judicious residence in mountain altitudes leaves little to be desired, providing that the daily routine is managed on anti-neurasthenic lines. I saw in consultation with Dr. Frederic Nield a lady in the forties who was the victim of repeated outbursts of uterine hæmorrhage of a severe character, with accompanying cardiac crises. Therapeutics were powerless to prevent the recurrent bleeding; she came to town, and was curetted. I found a bulky uterus, with no clear signs of malignancy: the microscopic evidence was also negative. The immediate result of curetting was satisfactory, but before long the hæmorrhage returned as before. I advised a prolonged residence at a high altitude in Switzerland. Thither the lady betook herself, and the hæmorrhagic record for some time was excessive. She resided at heights varying from three to six thousand feet, and often the hæmorrhage was so great as to confine her to her room for a week or two at a time. Gradually, however, the bleeding stayed, finally it entirely ceased, ultimately she walked down from the Gorner Grat to the Riffel Alp, that is, at a height of ten to seven thousand feet, with ease and freedom. She has since remained with practically no return of the hæmorrhage.

The remaining symptoms I can only briefly allude to. It was Professor Goodall who, with masterly insight, said that "groin aches and sore ovaries are far more commonly symptoms of nerve exhaustion than of diseases of the appendages." Thus much for ovaralgia.

Coccygodynia I have known develop during the oncome of neurasthenia, and cured by the general treatment prescribed for this constitutional illness.

II. *Pelvic lesions in women frequently engender chronic neurasthenia which may develop into an independent affection of the whole body.* This text should be repeated by the gynæcologist each morning on the commencement of his labours. Curiously it is not the graver affections of the pelvic organs—the malignant diseases, cystic growths or myomata, that oftenest engender neurasthenia, but such relatively minor affections as dysmenorrhœa, or uterine displacement with hypertrophy, or ovarian prolapse. These are the most frequent precursors of feminine neurasthenia. Moreover, no case where any of these pelvic conditions is persistent and developed is free from the imminent risk of chronic neurasthenia, even if the drift have not set in already.

Now, five-sixths of the constitutional symptoms observed in the chronic diseases of women are of neurasthenic character. I have already alluded to the common, but quite erroneous, notion that insistent constitutional symptoms, following on pelvic disease, are “pelvic reflexes.” In most cases they are nothing of the kind; they are distributed neurasthenic symptoms, chief indices of the neurasthenic state that has stolen on, unperceived, in the wake of the chronic uterine lesion. Now, their import as to treatment is this: in those cases where the vitality is average, the pelvic disease not pronounced, and the environment favourable, the organism has power enough to self-rectify after the pressing uterine cause has been removed.

But in those cases—and they are legion—where the vitality has begun to flag; where the environment is not favourable, and where the pelvic disease is old-time and pronounced, then the constitutional illness is neurasthenia pure and simple; it will not self rectify on the mere removal of the primary pelvic cause; it is now a disease in itself, and requires an anti-neurasthenic *regime* for its own special behoof, quite separate and apart from any local measures. Often, indeed, the constitutional state is by far the more difficult to cure.

This alliance of local and general disease, sequent but different, each requiring independent treatment, is of such prime importance to definitely recognise, that I must crave your forgiveness if I have dwelt with some prolixity upon it.

NEURASTHENIA AS RELATED TO SURGICAL PROCEDURES.

This relation is twofold, and each aspect is of importance :—

I. *Neurasthenia as a direct issue of some surgical procedure.* Our attention was first drawn to this by a distinguished German physician at one of the great spas. He remarked on the number of post-operative cases which repaired to the spa waters to recruit, adding that operators often did not see their patients, as the physicians did, slowly recuperating months after the surgical glamour was over.

Savill also definitely fixes surgical procedure as a cause of neurasthenia. Of this I have repeatedly seen cases in my own experience, and I believe that the neurasthenic condition may arise, not only during the operative convalescence, but also, as after some railway accidents, as a deferred issue, insinuating itself months after the causative stress. Of this I have recently seen a very marked case.

II. *Neurasthenia as the underlying radical state in surgical cases where the lesion is a defect, not a disease.* I allude to the numberless cases where ptosis of this, that or the other abdominal organ exists; whether kidney, or stomach, or liver, or intestines, or uterus. Now these are, clinically, diseased states, in that their presence is associated with a number of well-marked clinical symptoms. So the kidney is fixed in position, or the uterus is sutured as nearly as possible where it ought to be. Yet no considerable or permanent benefit often ensues. Why is this? Simply because the dislocated organ is living and moving as part of a more generalised neurasthenic state; and it is patchwork of the veriest description to pick out what Dr. Gould well calls the “most insistent symptoms” for treatment, and to pass by on the other side with regard to the residual constitutional state. Often the *venue* is thereupon transferred

to some other organ; often the benefit expected does not ensue, in spite of the surgical success; because the ganglionic centres are waiting for that restored vitality which, when brought about, gives to the operation its full meed of success; for without such operation, in fact, the generalised improvement often could not be effected.

(1) May I again put it as plainly as possible? The most prominent cause of neurasthenia in women is some antecedent pelvic disease.

(2) But once contracted, the neurasthenia may and often does continue after the pelvic cause has been removed.

Two concrete cases may fitly illustrate these statements.

(1) *Neurasthenia originating from pelvic disease.* A lady surrounded by all the refinements and luxuries of civilisation, and with no hereditary taint, had excellent health before marriage. The first confinement passed without note; the second was followed by neurasthenia that increased with the increasing years. She was afraid to drive lest the horses should bolt, lived in a state of chronic hopelessness about her future, and was perpetually bathed in tears. Walking shook her, bath chairs jolted her, and she spent her days in the circle of her own establishment. Cardiac crises recurred again and again, and each monthly period was a scene of tumult, followed by prostration. The period was neither excessive nor painful, but the results were devastating. The uterus was the uterus of chronic metritis. I attended her for several years, and as the menopause was instituted, she gradually got better; and now her recovery is spoken of as marvellous by her friends.

(2) The other case of *neurasthenia, persistent after pelvic rectification*, is in its way quite as suggestive. A lady, brought to me by one of our colleagues, had had one child. The health of this little one left much to be desired; so the husband and wife, determining not to dower the world with further specimens of ill-health, agreed henceforth to live a life of marital celibacy. This they did, with the issue that the lady's health completely broke down, with local symptoms referable to the pelvis. The generalised defects were those typical of neurasthenia. I removed the diseased

appendages and thus stopped the periods, but apart from this no benefit ensued. Chronic neurasthenia has crippled and spoiled her life ever since; insomnia, neuralgia, constant fatigue, anorexia, palpitation, perpetual drenching axillary perspiration, make up the *tout ensemble* of a limited existence. She has had therapeutics of all sorts, but will not consent to a thorough Weir-Mitchell course. Now, I doubt if it would possess material benefit for her.

TREATMENT.

All the foregoing facts are but items of academic curiosity unless they can each take their part in the scheme of treatment.

I hold that every fact and every item of knowledge—clinical or pathological, direct or collateral, that we can gain with regard to disease is germane to its effective treatment.

Now, I have learned to unlearn several heresies that are taught directly or by implication concerning neurasthenia.

I. I have learned to unlearn that neurasthenia, when of a chronic character, can be cured in any extraordinary manner in a few weeks, or even months. That the most insistent or the latest manifestation can be thus submerged I have no doubt. But this is not the disease in itself; some slight stress of illness or fatigue, and lo! the former symptoms, or various quite new ones, are on us with as much insistence as ever.

II. I have learned to unlearn that—in chronic cases—the patient is safe in any period less than a year and a half to three years after the commencement and pursuance of systematic constitutional treatment. I have adopted as a working hypothesis, that what has to be brought about as cure is no less than the entire replacement of the molecularly disarranged protoplasm by new nervous structure; that the ganglia involved require regeneration; and this has a striking parallel in the phenomena of the menopause, which in marked cases require the same length of time for their subsidence.

III. I have learned to unlearn the error, that massage,

or high pressure feeding, or the D'Arsonval current, can cure in any other way than by providing the ganglia involved with stimulus and pabulum to regenerate. The tissues may be laden with fatty material, the product of massage; the walking powers of the patient may be as good as ever; but the cerebral symptoms, if such be present, may continue quite uninfluenced in the betterment, until the nervous centres themselves have had time and opportunity to be regenerated.

IV. I have learned to unlearn the dangerous errors that a Weir-Mitchell course is a final or complete measure, that it needs no safeguarding to prevent its issues being frittered away, or that no supplement or complement is necessary with its use. No case of Weir-Mitchell is complete without Swedish exercises as a part; a Weir-Mitchell course requires maintaining and amplifying by Swedish exercises for a good year, year and a half or two years after its prescription. Why so many suitable Weir-Mitchell courses are unproductive is that it is not recognised that all these can do is to lay the foundation of improved health; the superstructure requires to be built during one or two years by remedies, by Swedish exercises, by mountain altitudes, and above all by a continued milk surplus dietary.

V. I have never learned, and therefore I have not unlearned, the gratuitous error of explaining neurasthenia by some fanciful analogy to storage of nerve force, and the running down of batteries, &c., &c. Such analogies are not based on experimental evidence, do not correspond to the facts of the case, and are merely specimens of slack thinking.

VI. I have learned to unlearn that it is expectable to finally cure—I do not mean symptom remediation—but wholly cure *marked* cases of neurasthenia by therapeutic measures unless on a Weir-Mitchell basis. After this, remedies are of much more avail, and probably a material obstacle to cure is removed. I have seen cases of Weir-Mitchell fail in part because therapeutics were thereafter neglected, and I have seen cases well and carefully prescribed fail in that a basis of Weir-Mitchell treatment had not been prescribed.

VII. I have learned to unlearn that surgical operations are in themselves actual curative measures for neurasthenic states. Whether it be stitching of the kidney, or some pelvic operation, or gastrorrhaphy, these act by removing an embargo to cure. The actual active suitable measures for cure find fit time and place after operation has removed a *per contra*. To surgically operate on a neurasthenic patient and imagine that thenceforth the general condition will self rectify is a fatal error. Chronic neurasthenia does not self rectify.

VIII. Lastly, I have learned to unlearn that in chronic cases any real progress can be made by merely blotting out with remedies permanent symptoms as they present themselves; of these there will be plenty. No condition is so prolific of varying symptoms as neurasthenia; but to merely dance therapeutic attendance on whatever group of symptoms is uppermost for the time, without, at the same time, taking sweeping measures for the betterment of the underlying state, this, I say, is simply to mark time and not to make progress. It is patchwork, not cure.

THERAPEUTIC AND EXTRA-THERAPEUTIC MEASURES IN NEURASTHENIA.

My experience in these cases is distinctly to the effect that the more chronic and confirmed the case, the more considerable is the part properly played by extra-therapeutic measures. Thus I have come definitely to the conclusion that the specific action of remedies is very greatly heightened by a prior course of Weir-Mitchell treatment, entire or modified. Nay, I have seen many cases where no progress with remedies seemed to be made, until a basis had been laid by massage and surplus feeding. Taking into account the length of time it requires to *cure* pronounced chronic neurasthenia, *i.e.*, from one to two years or more, it will be divined that much time is saved, and better results gained, by giving the organism an initial and generalised betterment by way of Weir-Mitchell. I have seen the action of well-chosen remedies apparently blocked and attenuated

until a thorough Weir-Mitchell course had been intercalated, and Swedish exercises thereafter carried out.

To avoid any misinterpretation, I may say that I do not believe Weir-Mitchell treatment *cures* marked cases of neurasthenia. I am of opinion that what it does is to give the organism a good start in the direction of recovery, but this good start, in fact, has to be amplified for many months after the Weir-Mitchell course is over.

I am of opinion that therapeutics actually *cures* chronic cases of neurasthenia, and that without these many a case merely treated by extra-therapeutic measures sooner or later relapses. The more marked the condition, the more necessary is it to begin with a Weir-Mitchell basis and continue with a therapeutic superstructure for a considerable time.

THE HOMŒOPATHIC THERAPEUTICS OF NEURASTHENIA.

The place of homœopathic therapeutics in neurasthenic treatment has already been indicated. Many cases of sub-acute form and recent origin may be cured by therapeutic measures alone, given the removal of causative agencies.

But in all cases I maintain that the cure is either incomplete, or recurrence of the illness sooner or later is to be looked for, until a diathetic and symptomatic course of therapeutics is diligently instituted. My experience clearly indicates that cure without therapeutics is on a very insecure foundation, and that the treatment of diathetic taints is just as important as the remediation of insistent symptoms.

There is no necessity to give in detail the indications for particular remedies. The *materia medica* provides these. The gonorrhœal and tubercular taints need in particular to be included in the area of prescribing. Nosodes such as tuberculin, and animal extracts such as adrenalin, are of especial value, and the higher dilutions of nearly all the remedies used are much more fertile in result than, for the most part, the lower potencies. This note of caution especially applies to neural remedies like picric acid. I have had several unpleasant experiences from giving this remedy, in

low potencies, for neurasthenic symptoms. The sixth I have known more than once to add to and not lessen the patient's sufferings.

ANIMAL EXTRACTS AND NOSODES.

Were I asked as to the treatment of the future in chronic neurasthenia, my opinion would emphatically be given in favour of nosodes and animal extracts. I believe that for these, both in physiological dose and in attenuation, a fertile and brilliant future lies. I realise that the accessory treatment of neurasthenia, whether by high tension current, or by phototherapy, or by rest and ample feeding, or by high altitude residence, works in a circuitous and indirect way, in that, by heightening the tone and stimulating the energies of the whole body, the foci of the abnormal condition are caught up in the general betterment. I also recognise that the effective remedy, be it polychrest, or nosode, or animal extract, acts ultimately by restoring the balance of the affected nervous molecule, and thus conferring a higher grade of immunity in the neurasthenic to depressant influences.

For similarity in nature, as well as for directness in operation, no drug-therapy can compare with remedial measures of the same character as those that probably cause and maintain the disease. I mean products of animal origin.

I much regret that this most promising line of treatment in neurasthenia—one of the new methods in homœopathy—still requires to be worked out.

DIETARY.

If, then, the treatment of neurasthenia is to permanently heighten the standard of metabolism of the individual patient, the proper selection of raw material in the shape of foodstuffs is of prime importance, for these contain the matter and energy out of which a higher grade of molecular structure in the nervous centres is to be evolved.

Two errors in dealing with this subject frequently appear. The first is that the nervous system in and by

itself can have its nutrition heightened by special foods, without the simultaneous generalised inclusion of other body tissues in the improved metabolism. For this view, a kind of short circuiting in dietary, there is, I regret to say, no clear evidence. The only way to secure specific nervous improvement by diet is to ensure general bodily improvement; and the diet must therefore be a representative one.

The second error is that the putting on of fat, in and for itself, is a desirable end; and that the progress of the patient is measured by his increase in weight. This is a radical error. The intake of fat, deposited again at various depôts in the body, corresponds to a certain surplusage of fat in the dietary. As a surplusage it is re-deposited at certain depôts in the body, and here, unless utilised again for metabolism, is as useless in the connective tissues of the patient, as though it still lay in the connective tissues of the providing animal.

Now, our object is to heighten the stability of the nerve centres at fault—to regenerate their molecular organisation to a normal plane, while daily they continue in function, and the requirement is to supply the whole organism with a representative food. Next, as the digestive power is almost always at fault, this representative food must tax the digestive powers of the patient the very least. Finally, after digestion, the food must lend itself as readily as possible to the repair of waste. That representative food is milk.

This organised food is clinically the most perfectly adapted to the rectification of the neurasthenic organism in point of foodstuff. I would even go so far as to say that without this animal food as a source of tissue and energy, the majority of chronic neurasthenic cases would be incurable. A patient may continue well supplied with ordinary foodstuffs for a long time, and make no progress, but when milk in sufficient quantity is superadded to the dietary, and active or passive muscular exercise simultaneously taken, the vitality rises, the capacity for sustained exertion increases, the nervous vigour is more readily recuperated.

How to give milk is of equal importance as the necessity

of giving it. It is usually prescribed in jorums of a tumbler at a time at intervals during the day, and the patient soon complains that she cannot take it, or is "sick of milk." No wonder. I learned the proper method from Sir Patrick Manson when I was under his care in Hong Kong. Take milk, as you would soup, through the medium of a spoon, so that each spoonful is well insalivated before it is swallowed, Sir Patrick suggested; and I took mine with a teaspoon; but in these colder climates a dessert-spoon may be substituted. This is by far the most effective way of taking milk, and when patients are laid up, it is the only right way. For ambulatory patients I adopt a slight modification. I direct that a wineglassful be slowly sipped every hour during the day, as the clock strikes. In this way the small quantity taken does not try the digestion, nor is it in sufficient bulk to spoil the appetite for meals, yet at the close of the day about two pints will have been presented to the system in a very assimilable form.

Milk charged with CO_2 , or diluted with rice or barley water, or with soda water, or plain hot water, are sundry of the substitutes for pure milk. But I am firmly of opinion that milk for neurasthenics is as important as milk for infants. Of the curative dietetic value of milk in neurasthenia I had some years ago a vivid illustration. Late in the nineties I saw in consultation one of the worst ambulatory cases of neurasthenia I have ever seen. The patient was a lady, emaciated, distressed, miserable. Her husband accompanied her, and his story gave point to the lady's statement. He was a financier in the city, "and often" said he, "I receive telegrams of an alarming character: 'come home at once,' 'Am dying, return immediately,' and similar urgent messages. You may guess," said he "what peace of mind these give for financial work." The lady was brought to me for uterine symptoms; these I quickly tailed on to the other neurasthenic bodily symptoms, but the *tout ensemble* was so marked and so forbidding that I held out to myself scarcely any prospect of the patient's recovery. She had had medicines before; I believe I suggested others; but I laid the greatest stress on the addi-

tion of milk to the dietary in the way I have mentioned. I saw no more of the patient then, and privately marked her off as one of the incurables.

But eight years after she returned, fat and well. Enquiring if I remembered her, "Indeed, I do, said I : ? What have you done ?" "I followed out your directions strictly. I took a wine-glass of milk every hour daily, for three years. It was then no longer necessary to continue it ; I was well, and I have been since in better health than I ever remember before in my life."

SWEDISH EXERCISES.

Half the battle of treatment is in the proper presentment of foodstuffs. The other half is in the heightening of the metabolic activity of the body so as to properly assimilate these foodstuffs. These two remedial measures are inseparably linked.

If we take an average patient with chronic neurasthenia, we usually find the general musculature of the body debilitated, and usually the defect in the musculature is most seen in the abdominal parieties. The abdominal walls are toneless and flabby, and without resistance ; the intestinal musculature is in the same condition, and allows descent and bulging of the whole intestinal mass ; the right kidney can be felt in a state of ptosis, and the upper limit of gastric resonance is often much increased. If such patients are asked to take a deep breath, the lower ribs scarcely expand at all ; the thorax ascends bodily, there is no diaphragmatic descent. Examination shows just such a condition as is found in the abdomen generally, to be repeated in the pelvis ; the musculature of the pelvic floor is weak, flaccid and descends ; the uterus usually follows suit, the organ is prolapsed or bent, and with this comes that drag in the back with which prescribing practitioners are so familiar. Now what is the physiological cause of this array of symptoms ? In brief, it is the lack of retentive power of the abdomen, and this is only another way of expressing a neurasthenic musculature.

Massage helps all these conditions but little. It is

increased power that is wanted, and here Swedish exercises come in as the panacea. Exercises adapted to cause healthy expansion of the lower ribs, to strengthen the abdomino-pelvic musculature, to invigorate the muscles of the back, these are the local measures adopted; while the other issues are the increased oxygenation of the blood, the more forcible contraction of the heart, the heightened tone of the visceral muscular coats, the obviation of pelvic and portal congestion, and a very important accessory aid to the cure of constipation.

Now, the value of these exercises is, that they can be done by themselves. After some tuition, the patient readily picks up the methods and can continue them unaided. The proper time for their use is twice daily; after breakfast, and in the evening before dinner; from 15 to 20 minutes at a time.

Next to the proper choice of the exercises, and their fitting hour of institution, the most important point is the duration of their continuance. Now this is the rock on which most of the cases for Swedish exercises come to grief. In confirmed cases a year is at least required to make the improvement assured; I have seen a wholesale transformation in six months; but this time is not long enough to assure the permanency of the benefit. I insist in my most marked cases that they shall be continued for an indefinite time—at least for a year—preferably longer; and this, when once the habit has been formed, is most easily kept up, and sometimes never dropped.

Shorter periods of months, when a permanent and deep-seated alteration is required in the tissues, are waste of time and money.

MOUNTAIN ALTITUDES.

I place mountain altitudes as second to none of the remedial measures for neurasthenia. But the altitude must be rightly decided and the routine of life definitely ordered.

My introduction to the value of Alpine environment in neurasthenia was striking. An eminent lady, the victim

RESIDENCE IN MOUNTAIN ALTITUDES.

CASE I.



Before.

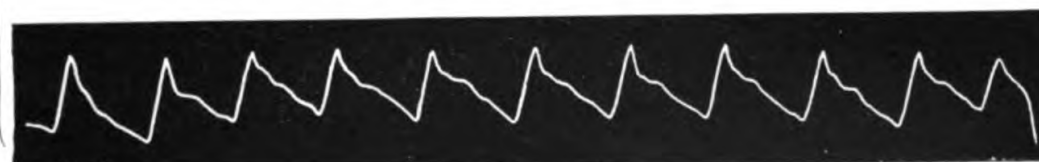


After.

CASE II.



Before.



After.

CASE III.



Before.



After.

CASE IV.



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of intractable hæmorrhage, with much nerve wear and tear, was curetted. The convalescence was incomplete. Some weeks elapsed; uterine leakage continued, the sense of ill-being persisted. At this juncture a move was made from Paris to the Schwarzwald. Here, at a height of 6,000 feet, the uterine leakage in no long time entirely ceased, the sense of well-being fully returned. I made a mental note of the case, for while the prescription of the curetting was mine, the prescription of the altitude was the husband's.

I had not long to wait for a replica of the former case, only more so. A clergyman's daughter, aged about 22, was brought to me in a pitiable state of neurasthenia, with pelvic symptoms. Further, the period recurred every fortnight, taking ten days on each occasion to its share; dysmenorrhœa was acute.

She was ordered to Switzerland. Now for the sequel. Six months later there came into my consulting room a well-set-up rosy girl, in whose *tout ensemble* it was difficult to see the pallid, nerveless maiden of aforetime. The pelvic symptoms had disappeared.

During the past five years I have constantly had neurasthenic patients, and neurasthenic-hæmorrhagic patients, in Switzerland, and, on the whole, with eminently successful results.

I have learned that many cases of uterine hæmorrhage can be regarded as neurasthenic, in that the hæmorrhage disappears under anti-neurasthenic treatment. And I have learned that mere residence in Switzerland, without a definite routine of life, dietary, and selected altitude, brings no more benefit than staying in England.

Thus a young lady of some 24 years, of strumous type, had suffered agonies from dysmenorrhœa for some years. Coming under the care of a famous Harley Street gynæcologist, he performed some operation, and sent her to Montreux. She returned not one whit the better, and the eminent gynæcologist then proposed to this girl of two and-twenty to remove the ovaries and stop the periods. To this she naturally objected. Coming under my care, I found a typical neurasthenic, with catarrhal uterus. I gave what local

treatment was necessary, followed by a thorough course of massage and Swedish exercises, sent her to Switzerland to reside at a level of at least 3,000 feet, with strict injunctions to continue milk and exercises daily. She remained in Switzerland nearly six months, made steady improvement the whole time, being able to do a good two hours' walk without fatigue, and with periods relatively painless in comparison with the former ones.

Consciously or unconsciously to the improving patient resident at altitudes, what actually goes on is a modified and specialised form of training. It is in this way and to this end that the invigorative powers of mountain life all work. It is by the increasing capacity for work that the progress is tested; and this is training, pure and simple. Bodily work is divided into: internal work, *i.e.*, circulation, respiration, &c., and external work, *e.g.*, walking, &c. A properly balanced routine for a neurasthenic patient entails measures which will heighten the capacity both for internal and external work.

A mere passive or *laissez faire* existence at high altitudes fails to turn the new environment to more than a portion of its available account. To ensure increased metabolism, I always add deep breathing exercises, and much additional milk, to the daily routine of my neurasthenic at altitudes.

What altitude should be chosen? My best results have accrued from a range of from 3,000 to 5,000 feet. I usually begin with 3,000 feet. I have met with only one patient requiring to go lower for a few days to acclimatise. I do not find less than 3,000 feet as a continued level of any permanent value. The patient who had formerly spent a fruitless season at a level below 2,000 feet, returned later by my direction to Mürren (5,000 feet) where the greatest and lasting benefit was derived. Patients who proceed at once to the higher altitude of 5,000 feet almost invariably suffer from some of the symptoms of mountain sickness, which militate very greatly against satisfactory progress. As improvement proceeds, and the test is increase in sleep and increase in appetite, the patient may either do more, or mount higher.

Now, from practical experience, levels of 5,000 feet are as much as the acclimatised neurasthenic usually derives benefit from. Why this limit? The worked out rationale is an extraordinarily attractive one. At an altitude of 5,000 feet, in the town dweller, the signs and symptoms of mountain sickness begin. What are these? Here is the list as given by Leonard Hill: "shortness of breath, palpitation of the heart, nausea, loss of appetite, bleeding from the mucous membranes, vertigo, faintness, and, in particular, the difficulty of making any muscular exertion."

The striking parallel between these symptoms and those of the chronic neurasthenic can scarcely fail to attract attention. The similarity becomes more marked on further analysis. There is an acute and a chronic form of mountain sickness. Whymper styles these respectively "transitory" and "permanent" phenomena. Professor Angelo Mosso, the great authority on the life of man in the high Alps, also says, "we must distinguish two forms of mountain sickness: the acute and the slow form." And of the slow form "this is not accompanied by nausea or vomiting, the diminution of appetite and other digestive disturbances are less severe than in the acute, the difficulty in breathing, the palpitation of the heart and lassitude, cause much less annoyance, although they are more persistent."

These descriptions of mountain sickness might well be taken as a generalised statement of the main symptoms of a chronic neurasthenic.

Professor Mosso definitely tells us that "the most striking phenomena produced in us by the air of the mountains are all of a nervous nature," and further, that "the cause of mountain sickness must be sought in a disturbance of the nutrition of the nerve centres, and not in a simple physical effect of diminished pressure."

I maintain, therefore, and with every apparent reason, that mountain altitudes benefit in neurasthenia by virtue of their general homœopathicity to the condition; that moderate altitudes benefit because the similarly acting influences are here attenuated; that high altitudes are ill borne because their action on the neurasthenic is of the

nature of physiological overdose. To carry the parallel further, the altitude, like the dose, has to be adjusted to the susceptibility of the patient; and, commonly, a slowly increased altitude-dosage confers some sort of immunity.

What, then, are the specific values of mountain altitudes for neurasthenics?

There is the *general heightened metabolism*; for residence at high altitudes greatly stimulates bodily metabolism for those resident in the plains. This heightening of metabolism occurs in the resting as well as the active life. It was observed by Zuntz—a trained observer—from the second day on Monte Rosa, and lasted the whole of his three weeks' residence there.

If the resting metabolism is markedly increased, still more is that of the walking. A slow walk on Monte Rosa exceeded the oxygen used in Vienna during a fast walk by 25 per cent.

There is the *heightened insolation* or increased effect of the solar light rays. The temperature may be at or about zero C.; but the skin is browned or inflamed by the sunlight. Widmark has shown that only the violet rays produce this inflammation of the skin, and Cornu has shown that at the Riffelberg the violet rays in the sun's light are there more abundant.

There is the *increased pulse and respiration frequency* at moderately high altitudes; but here, as with metabolism, the increase is for those usually resident in the plains. Jaccoud found at St. Moritz (6,000 ft.), an augmentation of from 12 to 18 pulsations and about five respirations per minute. Veraguth observed a less increase—about eight beats per minute, and this chiefly in the first week. After stiff climbing, the increase is, of course, much greater.

Again, this applies only to dwellers in the plains; for the two hut-keepers had the same pulse rate at the end of the season as before they went up at the commencement. The increased pulse and respiration rates for town dwellers diminish after a few days; training, in fact, is going on.

There is the *increased formation of hæmoglobin*, and an *actual increase in the number of red blood corpuscles*,

probably due to the increased activity of bone marrow. Dr. Egger, at Arosa (6,000 ft.), on examining twelve persons, found an increased richness of blood in all but one.

NEURASTHENIC TYPES AND THEIR TREATMENT.

Cases of chronic neurasthenia practically present themselves as the *ambulatory*, the *decadent*, and the *persistent invalid*.

The ambulatory cases, such as frequent hospital out-patient departments and physician's consulting rooms, require a definite line to be taken at once if treatment is to be successful. The exciting causes are probably still in operation, and require hunting out and eliminating with conscientious thoroughness. Insufficient food and excessive tea drinking, late hours, insanitary conditions of work, oral sepsis—these are types of exciting cause that, while persistent, render treatment futile.

Next I must insist for the insurance of the cure of these cases, that some new element making for health be introduced into the daily life. I know none better, as a rule, than the systematic performance, year in and year out, of Swedish breathing exercises, providing that these are done at proper times, not slurred, and that additional milk is added to the dietary while these are being continued.

An exposition of what may be done in this way is given in a valuable paper by Dr. E. A. Neatby, in the *Monthly Homœopathic Review*. These extra-therapeutic methods are absolutely necessary as accessory measures.

In these ambulatory cases, then, it is necessary to eliminate still operating causes; to exercise to the full therapeutic measures; to employ at the time, and as a persistent element in the life, some extra-therapeutic procedure.

Turn now to the *decadent*; and by this I mean the marked case of chronic neurasthenia with a steady trend downwards. The patient is still an ambulatory patient, but is unable to be of any service to herself or others from recurrent crises, as well as from a degree of ill-health that prevents continuous application. These cases recover with

exceeding difficulty and slowness unless and until an initial Weir-Mitchell course be given. These decadent cases require a supervised treatment for two or three years, and the same may be said of these as of the merely ambulatory cases, they require some new element of hygiene infused into their lives to make the cure assured. Life in mountain altitudes, together with daily Swedish exercises, is frequently as excellent a measure as can be found to lead off with when the ambulatory stage is regained.

The persistent and chronic neurasthenics require for their restoration to health—and I believe that with sufficient time and sufficient trouble 95 per cent. of neurasthenic cases can be restored to health—I say the persistent and chronic cases require, beside a Weir-Mitchell initiation, a much more prolonged and varied scheme both of therapeutic and extra-therapeutic measures than can be dilated on here. Concerning the latter I may briefly indicate the high frequency current, the electric light bath, static current from the Wimshurst machine, the use of hydro-therapeutic measures, as having all in their turn given me excellent results in various cases.

But I must again insist on the fact that as the illness is a polyphasic illness, that the treatment must be polyphasic also. In my own experience there is no one class of remedial measures, whether purely therapeutic, or purely Weir-Mitchell, or purely electrical, &c., that will cure the majority of neurasthenics. But I have, and I have reason to have, every confidence in the adequacy of modern measures of treatment, carried out on a basis of homœopathic therapeutics, to cure instances of this curse of the civilisation of the twentieth century.

Dr. SPEIRS ALEXANDER (in the chair) said that the impression which the paper left upon his mind was that of the vastness of the subject, and the very large view which it was necessary to take in these cases if anything was to be done for permanent cure. The paper seemed to explain what had been phenomenal to some minds—that, if pelvic operations had been performed, the patient was not only not cured, but sometimes rendered worse.

There were one or two points in which he was much in accord with Dr. Burford. One of them related to the Weir-Mitchell treatment. That treatment had been very much abused, and he had again and again observed what Dr. Burford had put forward, namely, that it could only be regarded as a foundation, upon which a superstructure of after-treatment had to be erected. He should have liked to hear from Dr. Burford something about the relation of alcoholism to these cases. As a result, he supposed, of long-lasting distress, some people were led into alcoholism as a relief to their sufferings. As to high altitudes, he had had an extensive experience of them for many years, but it had not been his lot to see much of mountain-sickness. He had seen it on one occasion only, and that was at the top of Pike's Peak, in the Rocky Mountains, at an altitude of over 14,000 feet. He had not seen neurasthenia on the Swiss or Austrian Alps.

Dr. CLARKE said that the paper was full of genuine experience, and was not a hash-up of what could be got out of books. This was what gave value to a paper. With regard to the treatment of neurasthenia, he thought that they should go one step further than Dr. Burford had attempted to go. In his experience neurasthenia could be traced in a very large number of cases to a number of causes which homœopathy was in a position to meet, and these were to be got at very largely through the family history of the patients. He thought that they could trace many cases to either a tubercular, or a vaccinal, or a cancerous diathesis; and he had found that he obtained the best results in giving some deep constitutional remedy of the type indicated. He might mention that an American lady who had been in Paris told him that the French doctor she was under there made a great generalisation and said that all American ladies in middle life suffered from indigestion, floating kidney, and neurasthenia. He (Dr. Clarke) had not attended "all" American ladies of middle life, but he had treated a goodly number, and he thought that the French doctor's generalisation had a great deal of truth in it.

Dr. DYCE BROWN said that he fully coincided with the remarks of the President and Dr. Clarke with regard to the interesting and admirable paper just read. It was too late in the evening to enter into the question of medical treatment, but he thought that it was most important to form distinct views of what he might call the pathology of neurasthenia, and to put away from one's mind the seeming prominence of certain so-called local disorders. It had been his experience for a long time that, as Dr. Burford

had very clearly pointed out, neurasthenia was really a constitutional affection, and that the various so-called local troubles were not to be treated specially, but were parts of the whole complaint. With regard to the pelvic condition, the cases which he had seen had certainly not been cases at all suitable for surgical treatment, and they had benefited by properly regulated homœopathic treatment. In some cases, no doubt, there might be uterine disease which had set up neurasthenia, but in most cases the disorder was constitutional. He felt that if they took that view it would help very materially in putting a stop to surgical treatment which did not really benefit the patient essentially. The beauty of homœopathic medicines was that all the medicines which were of real use in neurasthenia were what they might call polychrests. It would be found that most of them had distinct uterine characteristics, and in the treatment of neurasthenic cases they must go more and more into the general condition of each individual, and see what medicine a particular case implied. The more careful the detail into which they went in ascertaining the symptoms, the more nearly would they be able to choose the medicine which suited the whole condition. This, he believed, was the line which in treatment they would find most effective. Instead of going for local conditions specially, they should observe the medicines which corresponded to the whole constitutional state.

Dr. GOLDSBROUGH agreed that the subject was one of the greatest interest. He should like Dr. Burford to give them a little more light upon his doctrine of nervous energy. A most interesting point connected with the subject was the occurrence of the malady in what was called genius. John Ruskin and Herbert Spencer were notable instances of this, in addition to those mentioned by Dr. Burford. Might one suggest that the work of genius never could have been done had it not been for the exalted tone of the nervous system in the people who manifested it? The explanation of nervous energy was the very secret of human nature, and it was not explained or really elucidated by reference to such things as force or energy, although those terms were used for the sake of convenience. He (Dr. Goldsbrough) believed that the early successes of the Weir-Mitchell treatment, especially as instituted by Weir-Mitchell himself, a man of commanding personality, were due to the mental tone he was able to induce in his patients. They had to consider the influence of personality in a way which had not been thoroughly considered yet. He had a case in his mind which would have interested Dr. Burford. It was the case of a young lady of 22

or 23 years of age who had been a mandolin player, and who threw her whole energy into her playing, and got thoroughly neurasthenic in consequence. The symptoms pointed to involvement of the pelvic organs, but Dr. Goldsbrough had assured himself that there was absolutely nothing wrong there, and that the symptoms were the manifestation of neurasthenia pure and simple. In her neurasthenic state the girl was affected by slight changes and emotional disturbances. If these changes could be prevented, she went on very well in response to other treatment. As surely as any member of her family was ill and she had to think what could be done, she got her symptoms accentuated. In treating a case of that kind one had, of course, to consider whether any emotional stress present had been that of anxiety or overtaxation of the mental powers, or the opposite. In a large number of these cases the doctor had only to draw out the mental energy of the patient in order to exert a very favourable influence over the bodily symptoms. That was the sphere of treatment which had been neglected, and on this, it seemed to him, a great deal of the success of the Weir-Mitchell treatment was to be accounted for. Another interesting point raised by Dr. Burford related to circulatory and heart phenomena. Dr. Goldsbrough believed that no one theory of connection between the heart and the circulation would satisfy the demands of the subject, but they had to consider that the patient might be attacked from either point of view. From the heart the local circulation might be involved, or the local circulation might be involved with affection of the heart dependent on it. He had a patient whose hands turned blue when she came and talked to him about her condition, but the heart condition was relatively normal; and another one who manifested both heart and local circulatory phenomena under similar conditions. As to the original cause of neurasthenic states, he was indebted personally to Dr. Burford for introducing a point with regard to the development of girls. Some years ago, in the case of one or two patients of his, Dr. Burford suggested, very valuably indeed, that the development of a girl from 15 to 20 was very largely responsible for her pelvic condition subsequently, and that emotional states were very largely responsible for abnormal states of the pelvic circulation and otherwise.

Dr. MADDEN wished to add his thanks to Dr. Burford for his most interesting paper. One point which Dr. Burford had put very prominently forward was the absolute indefiniteness of the concomitant symptoms of neurasthenia. He had

shown the meeting a large number of sphygmographic tracings, and they were all different. There was not one of them which could be considered characteristic in any way whatever. One or two of them appeared to be absolutely normal. But Dr. Burford, while complaining that the authorities on neurasthenia denied that there were local characteristic pelvic symptoms accompanying neurasthenia, appeared to him (Dr. Madden) to entirely coincide with them, and to agree that, although there were plenty of local symptoms there was not one of them characteristic. The difficulty in these cases seemed to him to distinguish between those which were secondary to neurasthenia and those which were possibly the original cause of it, and without the removal of which it was not of much use to make a start upon the treatment of the neurasthenia. There was no doubt that certain pelvic symptoms did start neurasthenic conditions, and it was probable that until these primary symptoms were removed it was not of much use to treat the patient at all. A case which had come to his mind was very similar to the one as to which Dr. Burford had told them how the patient went to a mountain altitude. It was a case of very marked neurasthenia in a married lady, whom he had been treating some time by Wier-Mitchell and general treatment. She made no permanent improvement. The only exercise which she seemed willing to attempt was cycling or walking, either of which gave her feelings of great exhaustion, therefore she never kept them up. Her husband then prescribed motor riding, and the result was excellent. When he (Dr. Madden) left her she was still remarkably neurasthenic, but a year later, when she had had simply an open motor without any treatment at all, she was markedly improved, and she had lost her neurasthenia altogether.

Dr. WATKINS said he need hardly say how much he had appreciated Dr. Burford's original paper. He understood that Dr. Burford had said there was no known pathological anatomy of neurasthenia, and then went on to say that it was the same with regard to chorea; but the speaker thought that the latter matter had been settled by Drs. Paine and Poynton and others, who had demonstrated the presence of the *Micrococcus rheumatica*. Dr. Burford had drawn attention to the normal appearance of the blood in neurasthenics, although patients looked so very anæmic; but he had not spoken of the polycythemia which is frequently present; i.e., an actual increase of the number of red cells. In the blood-counts which Dr. Burford showed on the screen two of them were above the normal of the blood of

females, and one reached as high as 5,150,000 per cm., but sometimes they go up to six or even seven millions. This increase is supposed to be due to vaso-motor disturbance. The only neurasthenia which is attended by anæmia is that form which is caused by masturbation and is always accompanied by the pale pasty complexion. He could testify that one of the patients which Dr. Burford had passed through the Wier-Mitchell treatment was not by any means cured until it was succeeded by a prolonged course of Swedish exercises.

Dr. E. A. NEATBY said that there were three points on which he should like to speak briefly. First, he would ask Dr. Burford if he would kindly confirm what he (Dr. Neatby) thought he said, which seemed to have been a little misunderstood by some of the speakers already. He understood Dr. Burford to say—and he (Dr. Neatby) himself held the opinion—that if there was a definite local organic condition it required removal before the constitutional condition would have a good chance of success.

Dr. BURFORD: Yes. I used the word "embargo on progress."

Dr. NEATBY, continuing, said that he gathered from Dr. Dyce Brown's remarks that he did not entirely hold that view. He (Dr. Neatby) thought that the view was a correct one, and that a definite local condition did require local treatment. There were a good many subjective pelvic symptoms in neurasthenic patients which required no local treatment, but which would be cured by the appropriate constitutional measures which Dr. Burford sketched. Dr. Burford briefly alluded to another point in mentioning a cause of this condition which he (Dr. Neatby) thought frequently happened in these modern times, and it was well to have the mind on the *qui vive* to give advice; that is, the prevalent habit of preventing conception, especially in newly-married people. He thought that this was a very fertile source of nerve disturbance, at all events in women. It frequently resulted at times in symptoms, as also did other perverted marital relations. Dr. Burford had sketched out very fully a treatment for neurasthenia, both medical and physical. Long before he (Dr. Neatby) was definitely interested in gynæcology he took an interest in the treatment of neurasthenic women. One point which he should like to suggest had reference to the fact that many people were not able to go to higher altitudes in order to get the benefit of rarefied air. Although these people suffered to some extent by not having facilities for this purpose, yet one could do a good deal by bearing in mind what Dr. Burford insisted on, viz., that a long time must be spent in getting them

well, whether by high altitudes or otherwise, and that a great deal could be done by what he (Dr. Neatby) had termed "life by programme." After patients had come out of a nursing home he had written out for them a definite daily programme of treatment to be followed for six or eight months, beginning with the experience that he had gained of their ability while in the nursing home. He had planned out their lives by the quarter-of-an-hour, or the half-hour at a time, giving alternate rest and exercise, and varying the exercise from time to time by prescribing mental and bodily exercise and occupation with different kinds of hobbies, to keep them trained both as regarded their muscles and their minds, and also rested at the same time. He thought that after a graduated programme of that kind they would be able in six or eight months to throw off a good deal of the restraints of medical supervision and become practically well. The length of time varied, of course, very much with the cases, but he thought that life by programme would do something towards meeting the needs of those persons who could not go away and have the advantage of a long residence in high altitudes.

Dr. F. H. BODMAN said that they were all indebted to Dr. Burford for his paper. He had come a long distance to hear it, and had not been disappointed. He did not think that Dr. Burford had laid very great stress on the fact that toxæmia of some kind was generally at the root of all these cases. The toxæmia might be due to some bacillus, or it might be a form of auto-intoxication, the result of indigestion, either gastric or intestinal, or it might be caused by the excessive use of tea or tobacco. As to treatment, he thought that patients who could not afford to go abroad, might gain in this country some part of the value of high altitudes by means of regular deep breathing. He often instructed his patients to exercise themselves in that way when they were walking out of doors, in good air anywhere. By this means the blood became oxygenated, and he thought that that was a very great help in the cure of neurasthenic cases. Another point was that great care should be taken in the proper mastication of food. Not only should they take proper food, but they should pay special attention to the complete and thorough mastication of it. This would obviate the symptoms of indigestion. He thoroughly agreed with the recommendation of milk, and he believed that it was the most valuable of all food. He would add beaten-up eggs to the milk; there is a considerable amount of lecithin in eggs, and this is a nerve food. A schoolmaster who was the subject of neurasthenia, and could not play games with

the boys on account of muscular weakness, commenced the habit of drinking large quantities of milk, and he regained his strength in consequence and could play games as previously. The result was due partly to his drinking milk. The patient also commenced to play golf, which, no doubt, had some effect in the cure. Anything which tended to oxygenate the blood must help to cure the disease. He had frequently seen great benefit derived from the frequency currents, indeed, it seemed to be of more distinct benefit in neurasthenia than in any other disease. He once brought a lady patient to Dr. Burford, who recommended curetting. This was adopted, and the lady went to Switzerland and lived there at a moderate altitude for about three months. When she returned she was not very much better, and he (Dr. Boiman) put her on high frequency. In a fortnight she had gained far more in health and strength than she had done during the three months in Switzerland. When she had relapsed after an illness, as she did after influenza, she had a short term of high frequency, and she immediately began to improve. He had used high frequency in a great many diseases, but it produced the most beneficial results in neurasthenia.

Dr. JOHNSTONE said that he had been very much interested in the newness of the views which Dr. Burford had brought forward on this interesting subject. Neurasthenia had been an almost hopeless subject to medical men as regarded the different manifestations of the disease, the great differences of treatment, and the most unsatisfactory results. He could only advise them to put in practice those precepts which Dr. Burford had been teaching to-night. He believed that, if they carried out the details and waited for results, they would be amply satisfied at having given the treatment a trial.

Dr. GRANVILLE HEY replied. He said that there was much which Dr. Burford had not said in the paper, and several of the points had been referred to by those who had taken part in the discussion. He did not know that he was in a position to answer all that had been said. For instance, he was not quite able to follow Dr. Goldsbrough's deep thinking. It was too psychological for him to go into. Dr. Bodman had referred to the question of mastication. It was a much more important thing to pay attention to the condition of the mouth itself, *i.e.*, to the masticating apparatus, than to the extent of mastication. If the gums were in a state of chronic pyorrhœa the patient would be absorbing toxin by the ounce, and this would lower the vitality and make the patient worse. With regard to the treat-

ment which had been advocated all round, one was bound to agree with what Dr. Johnstone had just mentioned. Personally, he could speak from his own experience, he found that a great deal might be done with patience in cases of neurasthenia. He might, by way of illustration, give one case which was the most marked that he had ever seen. The patient, a woman about 50 or 55 years of age, who had been under some allopathic doctors, two of whom had refused to see her again, was under the care of a homœopath and had been seen by a homœopathic consultant, but seemed to get rather worse than better, in spite of her many physicians and much physic. He (Dr. Hey) then saw the case. At that time he had only been a homœopath for about eighteen months. The patient was the thinnest living person that he had ever seen. When he passed his hands under the bed-clothes to palpate the abdomen there was no abdomen to be found, only skin stretched over the bony prominences of pelvis, vertebræ and ribs. She had not eaten solid food for six months, or had any action of the bowels without aid for six months; she was taking pepsin with all her food, and was sure she could not do without it, and that there was no cure for her. He had to have recourse to artifice to rid her of these ideas. He gave the patient to understand that there was no reason why she should not get well as she had no physical counterpart for her symptoms. He gave suitable remedies to meet the worst symptoms, and at the end of two months the patient was sitting up in bed taking solid food and getting a healthy action of the bowels daily. Moreover, she had ordered a new dress. He had heard since from her medical attendant that she was now about as well as a woman could be, although she had made up her mind that she would never get well. With regard to the nervous manifestations, it was his privilege to be the first to point out the relation which was to be found between the superficial reflexes and neurasthenia. While he was going over the cases systematically in the wards he stumbled across the fact, and in nearly all cases of neurasthenia they would find a definite relationship between the superficial reflexes and the neurasthenic condition. There had been also some experiments worked out to show the relation between blood pressure and respiration in these cases. On the part of Dr. Burford, Dr. Ham, and himself, he desired to thank the meeting for the hearty way in which they had received the paper.

THE VALUE OF ACCURATE DIAGNOSIS IN
HOMŒOPATHIC PRESCRIBING.¹

BY JOHN HENRY CLARKE, M.D. EDIN.

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THE world of homœopathy and homœopathic ideas is something so widely different from the world of established State medicine that there is little ground for astonishment in the fact that allopaths fail to understand us, and in a general way condemn us for our virtues and applaud us for our faults. Nor is it astonishing either that we often ourselves get not a little mixed in our ideas. In point of fact, if we are not constantly on our guard, we are trying to think on two planes at once and coming to grief over words which are used in entirely different senses by different classes of writers.

Among the words which are a constant source of stumbling is the word "diagnosis." "Homœopaths," say our critics, "never give themselves the trouble of diagnosing a case; they only treat the symptoms." It is of no use trying to convince an allopath that this is altogether wrong, and I should never think of attempting the task. But I am under the impression that some homœopaths are rather influenced by the criticisms, and I think it may not be lost labour if I endeavour this evening to clear up this matter as far as I am able.

The criticism is, of course, founded on a certain amount of fact. There is diagnosis of disease, or nosological diagnosis; there is diagnosis of case, or individual diagnosis; and there is the obverse of this, remedy diagnosis. Now, the allopath knows only the first of these, whereas the homœopath has to concern himself with all three. In a general way it is the two last alone—the diagnosis of the individual and the diagnosis of the corresponding drug—which are con-

¹ Presented to the Section of Materia Medica and Therapeutics, July 4, 1906.

cerned with the finding of the remedy. It is on this account that we are often astonished by cures made by amateur homœopaths. These good people are not troubled with all the lore we professionals require in order to arrive at a nosological diagnosis, and are, therefore, much more free to hunt up *symptom* correspondence in repertories and *materia medica*s. Still we ought not to be disconcerted by this; we have a good pull over amateurs in other ways, and, at times, as I shall presently show, the nosological diagnosis is a very material help in prescribing.

But there is yet another diagnosis which homœopathic practitioners have to take into account, of comparatively small importance to allopaths, but of vast practical importance to us. I mean the *diathetic* diagnosis, or, as Hahnemann named it, the diagnosis of the chronic miasm.

As a result of his first years of homœopathic practice Hahnemann found that there was a lack of correspondence between some of his cases and the apparently homœopathic remedies. The remedies answered their indications and cured *for a time*, but the trouble returned in the same or another form. Hahnemann discovered that the reason of this was, that his correspondence was not perfect. There was an element in these cases which he had not matched in the remedies he had prescribed. This element, which he discovered, he named a "chronic miasm," and the three chronic miasms known to him were—psora, syphilis and sycosis. Each of these miasms was manifested by more or less definite symptoms, and when these symptoms were matched by remedies—and his later provings revealed which these remedies were—his cases were not merely relieved, but cured.

Now there is not one of these four varieties of diagnosis—the nosological, the individual, the diathetic and the remedial—which the homœopathic prescriber can afford to neglect.

A year or two ago I was asked to see an elderly lady suffering from a very evident attack of influenza. Under treatment the acute symptoms subsided within a short time.

But there remained a condition of fever with very little else in the way of symptoms, except weakness, and all my efforts at prescribing on the meagre symptom-list failed to make any real improvement.

At last, one day, the patient complained of a little pain in the right foot. She had felt it a day or two before slightly, but being a very reticent person she had not thought it worth mentioning. On looking at the foot I found it red, swollen, shiny and very tender. The mystery was solved! I was dealing with a case of gout and did not know it, until it hit me—or I might say kicked me—in the eye. And yet I might have guessed it before. The patient was an extremely gouty lady and the influenza had stirred the gout into action. *Urtica urens* ϕ (which Dr. Burnett discovered to be the pathologic simillimum of acute manifestations of gout) rapidly altered the state of affairs, and in twenty-four hours the fever had disappeared, and the foot had returned to nearly normal dimensions.

Is not this pathological prescribing? you will probably ask me. I answer, Yes, it is. And I answer further, when nosological diagnosis enables you to hit your pathologic simillimum, do it by all means and you will score every time. But do not forget that the pathologic simillimum is often just as hard to find as any other simillimum, and, further, do not forget that it is the simillimum you are in search of all the time, and not the name of the disease. Treating the names of diseases with the names of remedies is one thing, and treating a case with its pathologic simillimum is another. In our work we must always keep the correct homœopathic attitude. If we do that we shall find many different ways of striking the simillimum, and some of them will sometimes correspond with the remedy an allopath might prescribe. But that does not prove that the allopathic method is the better way, or as good. Even allopathy does make cures sometimes, but unless it ploughs with the homœopathic heifer, it cannot repeat the performance. You may treat fevers with antiphlogistics, cases of debility with tonics, of neuralgia with sedatives, but if you have nothing better than these names to guide you, your misses will be ninety-nine to one of your cures.

In May, 1904, I was written to about Mr. H. D., aged 53, a well-known citizen of a county town in Wales. The story was this: In 1902—this is about two years before I heard of him—he had influenza badly. This left him in a melancholic state, which lasted for months. This passed off and has not recurred. In August the following year (1903), he got wet through whilst driving in pouring rain. Before the wetting, in the beginning of August, he had felt pain in the right foot. From the time of the wetting he had felt the foot getting more painful, and it kept him awake at night. At last the condition got so bad as to cripple him. Local help availed nothing, and he was brought to London and there he saw three well-known consultants, Dr. P. S., Dr. F., and Mr. B. in consultation. Dr. P. S. gave it as his opinion that the case was one of neuritis. Dr. F. diagnosed tumour of the spinal cord; and Mr. B., who concurred with Dr. F., took the case in hand. Mr. D. was first X-rayed, but the photograph showed no evidence of tumour. Surgery is not to be daunted by negative evidence and so an operation was arranged. A puncture was made. Again with negative results. A week later more radical measures were adopted. The lumbo-dorsal spine was unroofed and the canal thoroughly explored; but as the missing tumour was missing still, there was nothing left to do but close up the wound. This was in January, 1904. As soon as he was well enough to bear the journey, Mr. D. was sent home to Wales with the diagnosis "Wasting of the spinal marrow," and was told that medicine and surgery could do no more for him.

After waiting for some months and bearing his sufferings as best he could, one of his sons wrote to me, and asked if I thought I could do anything for the patient. I said it was possible I might, and asked for full details. In answer to my queries I elicited that the patient had previously been a healthy man. He had had typhoid at the age of 15, had been twice vaccinated, once in infancy and once as a boy. His father was a healthy man and died from an accident. His mother had died, aged 68, from a tumour in the throat. The patient was the youngest of ten children, of whom

three had died of convulsions, one of croup, the others being alive and well. The patient was liable to bronchial colds when the cold weather set in.

The apparent net result of the operation was that in addition to the pain and loss of power of the right foot the left foot had also become bad and quite as painful and helpless as the right.

When I was first consulted about the case the pain was of a shooting character, right through the soles of the feet up to the knees. After a bad bout of pain the feet became swollen and discoloured. Right knee at times got swollen. Locomotor power of both feet was lost. Pain is worse after sitting up awhile. Is better in hot weather. Damp has no effect. When the pain is most intense the urine is reddish.

Such, gentlemen, was the puzzle set me; the question now was how to solve it. In attacking a case of this kind we have to make up our minds on which line of similarity to open the attack. There were several possible ones. For instance, there was the trauma of the operation, it had clearly affected the situation and might be taken as the causal simile for the first prescription. There was, again the exact similarity of symptoms, which we may call the classical similarity. This I adopted later with very great success; but a good deal depends on the start in a case of this kind, and there were other points to consider. We had here a case of pain and paralysis affecting the lower extremities, and the proximate cause of it was apparently the wetting. This would naturally call rhus to mind. But I particularly enquired before prescribing as to *when* the pain was felt first and ascertained that it was felt *before* the wetting. I came to the conclusion, therefore, that the essential cause was to be found elsewhere, and I traced it to the attack of influenza which had made such a profound impression on Mr. D. some eighteen months before.

Therefore, I selected this as the point of attack for the first prescription. I think Dr. P. S. was nearest to the mark of the allopathic consultants. The case was one of neuritis, the spinal cord itself being involved, and the influenza was the *still acting* cause of it.

Now, in the course of my materia medica labours I was struck with the similarity of the pathogenesis of *tuberculinum kochii* to the late effects of influenza as I had observed them in my practice. I had also noted the effect of an attack of influenza on phthisical patients, and have seen them rapidly broken up by such an attack. I, therefore, concluded that *tuberculin* of Koch might form the pathologic simillimum of late influenza effects, in the same way as *thuja* and the vaccinal nosodes are the pathologic simillima of vaccinosis, and as sulphur, psorinum and the other antipsoras are of psora. Experience proved that the law of similars in this was true as elsewhere, and I have confirmed the observation many times. *Tuberculin kochii* will not cure all cases—of course not. Every rule in homœopathy must be used with brains, and happily homœopathy has always a reserve when our first effort fails us. I prescribed for Mr. D. twenty-four powders, numbered from 1 to 24, three of which were medicated with six globules of *tuberculin koch.* 100. One powder night and morning in numerical order. This was May 16, 1904.

It proved a bull's eye. Nothing had ever availed to touch the pain before ; but the very first night after taking *tuberculin* he slept, and I do not think he has had a bad night since, though he has had plenty of pain in the day time.

May 31, 1904. Sleeps much better. Feels much stronger in himself this last week. Still suffers very great pain in his feet. Back still painful at times. Repeat *tuberculin koch.*, thirty-six numbered powders, four directly medicated.

June 11, 1904. Ever so much better in himself these last few weeks. Has slept soundly every night. Pains less frequent and not so severe as four or five weeks ago. No power at all to move the toes.

Pains are worse in the evening, a few hours before going to bed ; worse immediately after meals ; worse sitting with the legs hanging down ; worse when he gets cold.

I will summarise as briefly as I can the rest of this case. I kept him on this remedy till the end of June, then prescribed *rhus* and, after *rhus*, *secale*, getting as close as I

could to the symptomatic simillimum. In the meantime I told the son to encourage his father to try to move his toes, and to move them for him until he could do it himself. After the *secale*, which gave him a good lift on, I again put him on *tuberculin koch.*, and from September 15, 1904, to February 5, 1905, he made steady progress on this remedy alone. The pains lessened and the power very slowly returned to the feet and toes. He was able to walk with assistance and even to resume his place in his business house.

As I had done so much without seeing him, the friends naturally thought I could do much more if they brought him to see me. I told them by no means to think of it. I did not want to have my work spoiled by a long, fatiguing journey to London from Wales. However, I gave him leave to come in March of the present year, and he climbed up my not very easy two flights of stairs in the city without any particular difficulty. I then saw the ugly scar on his back, nine inches long, and some half dozen vertebræ wanting their spinous processes, proving that these, like the appendix vermiformis, are not essential parts of the anatomy. The centre of the scar, where the puncture was made, is still tender.

I found the right foot swollen, but not discoloured. He was able to move the foot on the ankle, especially to flex it. The left foot he could move very well, including the toes,

In the subsequent stages of the case *Plumbus acet.* 100. and *alumen* 100, chosen on the symptom-correspondence in the classical way with repertory and materia medica, very greatly assisted the progress.

The patient is now restored to his position in his town, not to his complete former powers, it is true, but to a state of practical efficiency. In a letter I had from him the other day he told me he had been able to wear a kid boot on the right foot and finds it extremely comfortable. Before then he was only able to wear a shoe, and that a largish one, on account of the swelling.

Now, gentlemen, it is very possible that I might have made as good a hit with the symptomatic simillimum, but I

could not have made a better. The impression that first prescription made on the whole community was wide and deep, for Mr. D. is probably the best-known man in the district, and every stage of his illness was public property. There was no rest and no ease for the unhappy man till my first box of powders gave it him. So whatever may be said of other methods of hitting the simillimum the importance of finding the pathologic simillimum is sometimes of the very first order. And before you can do this you must be able to diagnose the pathology of the case, and you must have works in which you can find the pathologic simillimum.

Before concluding I should like to say a word or two on the *implementa homœopathica*. I wish we could get away from the term "materia medica"; it means one thing to the allopath and it ought to mean something quite different to the homœopath. But strange to relate many homœopaths are not aware of this.

I was written to by a gentleman some time ago who asked my advice about getting a materia medica. He had been practising homœopathy for five years, he said, and as soon as he could afford it he intended to buy a materia medica! He added, which was very gratifying to myself, that he had found my "Prescriber" invaluable. Now, gentlemen, I am aware that my "Prescriber" has often proved a very present help in times of trouble; but the "Prescriber" can never take the place of the real *implementa homœopathica*. These are, in essence, a symptom list and a symptom repository. The homœopathic materia medica is as much like the allopathic materia medica as chalk is like cheese. You may smile at my correspondent, but he was not so behind the times as some may think. I have no doubt he possessed the "Pharmacodynamics," but he did not consider that work to be a materia medica. Yet I have known homœopaths who possessed that useful work, who were yet unaware that it is not a homœopathic materia medica in the true sense. Dr. Hughes himself knew well that it was not, though I do not know that he ever explicitly said so. But his works prove that he did know it. It is true he would have none of Hahnemann's symptom list or schema. Hahnemann's

schematic arrangement of the symptoms, he said, was a real calamity. But, like the true man that he was, Dr. Hughes set himself to work to redress the calamity, and he produced as the substitute for the schema his *magnum opus*—"The Cyclopædia of Drug Pathogenesy." Now, the man who backs his opinion by his works must ever command our deepest respect, and the "Cyclopædia"—which is an attempt to replace the schema with the day-books of the provers as a practical *implementum homœopathicum*—though it has signally failed to take its place as a handbook of practice, remains a magnificent storehouse for future workers in the field.

But for all that, gentlemen, the *implementa homœopathica* remain essentially what Hahnemann designed—a list of symptoms, supplemented by a repertory. The list of symptoms was introduced by prefatory matter. This prefatory matter may be extended considerably beyond the limits which Hahnemann gave himself in his "Materia Medica Pura" and "Chronic Diseases." Such prefatory matter we find in "Dr. Hughes' Pharmacodynamics," in "Kent's Lectures," and in my introductions to the symptom lists in my Dictionary. But without the symptom lists there is no homœopathic materia medica in the true sense. This was apparent to me many years ago, and it was the fact that I saw that Dr. Hughes was working on wrong lines as far as practice was concerned, that caused me to retire from his band of workers on the "Cyclopædia" and set to work on lines of my own. I saw that there was little use in criticising the work of others until I could supply its place with something which I considered better from the practical point of view, and more true to the genius of homœopathy.

I now find myself in the position that, having produced my work, I have to convert my public to realise that they want it. However, I daresay I shall accomplish that in good time. As soon as the homœopathic world has been brought to a conviction of its soul's needs in the way of *implementa*, I intend to start on a missionary expedition to the allopaths. They are not really happy in their minds as it is, in spite of all their shouting; and as I have nothing

else to do in the world, and am in no particular hurry, I have a powerful hope that I may yet succeed in bringing them to seek and find salvation. I have no doubt that I shall be able to count on the co-operation of this Society in the enterprise.

Please let it be understood that the allopaths have a perfect right to seek to extinguish homœopathy, just as homœopaths have the same right to seek to extinguish allopathy. The allopaths started the extinguisher game, and it is the barest civility on our part to play well up to it. I do not mean mere defence—that is as poor a compliment to our foes as it is poor tactics—but vigorous offence.

The only possible hope of amalgamation of the two schools lies in the extinction of one of them. The question is—shall the giant kill Jack or shall Jack kill the giant? For the last two generations there has been in the homœopathic body of this country a party who have been in favour of conciliating the giant. The result of this policy has been that the number of avowed homœopaths in Great Britain has been reduced from over three hundred to less than two hundred.

But I think, Sir, there are signs that this rot is going to be stopped at last. Jack is going into training in the use of his *implementa*, and it is the distinctive features of homœopathy and the skill of homœopaths in the handling of them that will finally assure the victory.

Dr. HAWKES (in the chair), after expressing the thanks of those present to Dr. Clarke for his exceedingly invigorating address, said that he had had to employ various methods of diagnosis, and in this regard a curious instance, illustrating the elasticity of the term, had occurred recently. He had seen one of his patients, who was of a nervous temperament, in the early part of the day, and his son saw her either in the evening or the next day. The chief symptoms noticeable were that the patient could not sleep or rest; moreover, she was very anxious about herself, and, although she rang him up by telephone, she was just on the point of sending for a doctor close at hand. It was not often one found every element of the case in the patho-

genesis of any drug, but under *cannabis sativa*, not only were those particular symptoms found, but in one case in the pathogenesis the patient felt so ill that she sent for a neighbouring doctor in addition. His son also elicited the fact, which helped them very much in the choice of the remedy, that the patient had been to see a friend, who reminded her so much of a deceased relative as to quite upset her nervous system; and there was no true physician present who would not agree that the last point was as important as any other. This might be taken as an instance of the broad diagnosis of the remedy. It would not be true for him to say that he quite agreed with the very wide application of the word "diagnosis" given by the author, but he thought everyone present would admit that Dr. Clarke was true to himself, and that the same lines of treatment and conduct were advocated in everything he presented to the profession. Dr. Clarke believed in his own methods, and he (the president) did not think Dr. Clarke would be happy until the rest of the profession believed in them too.

Mr. DUDLEY WRIGHT thought the case of neuritis referred to by the author showed how careful prescribing could bring a case to a successful issue, because in that case, without any previous history of tubercle or consumption, tuberculinum was given, and the patient was very much relieved if not cured. At the present time a good deal was heard about the opsonic index, and the treatment by tuberculinum in such cases where the index was lowered. There were cases which he presumed would not show any change in the opsonic index, and yet in which tuberculinum was of the greatest service, in which, indeed, there was no tubercle present, and possibly no history of tubercle in the family. Some cases of tumour of the breast were very greatly benefited by the administration of tuberculinum. Such facts as these showed, he thought, that the methods of the pathologist, good as they were, were not sufficient at the present time to indicate the various remedies which homœopathists dealt with. He believed it was the fact that some of the best prescribers did prescribe by means of intuition. They hit upon a drug without knowing exactly why they did so. It was a form of genius. The same remark applied to the old herbalists, who were extremely successful occasionally in prescribing different remedies, although they knew very little about them pathologically and chemically. The late "Pastor Kneip," of Bavaria, whose water-cure most present had heard of, was a very wonderful man in that way, often hitting upon successful remedies for the various

cases which came to him. He (Mr. Wright) was struck, in reading Kneip's book, with the fact that he used many of the drugs on practically homœopathic principles. As the discussion had taken rather a wide field, he desired to refer to the question of simplicity in prescribing. In taking up the *Materia Medica*, such endless arrays of drugs were to be found that the physician was at a loss to know which to prescribe. It was all very well for the author to say " Hunt it up out of the repertory," but even with the repertory the greatest difficulty was experienced in finding the right drug. He had often come across a symptom which was not mentioned in the repertory at all, and such cases had to be dealt with by intuition. He therefore suggested that the remedies should be simplified as far as possible and treated in a general way, such as Dr. Hughes adopted in his book, and he believed by such a means a great many remarkable cures were obtained. For instance, with regard to *urtica urens* as recommended by the late Dr. Burnett, did Dr. Burnett, when he prescribed that drug, always hit upon it because it was a *simillimum*? The speaker did not think so at all. *Urtica urens* covered the range of gouty symptoms, and the probability was it did a deal of good for that reason. Why others had not achieved success with that drug he did not know, except that it not infrequently happened one man was extremely successful with a certain drug and another man with the same drug was entirely unsuccessful.

Dr. JAGIELSKI thought that the general condition of the patient should be considered more than the particular symptom of pain, which was prominent at the time the patient came to the doctor. That was the reason Dr. Burnett was so successful in his practice, because in that way not only the general health of the body, but the particular ailment improved. The real object of the paper was to teach homœopathists to cultivate correct thought, and it was only by correct thinking that proper results would be obtained.

Dr. GALLEY BLACKLEY said that, while agreeing with a good deal of what the author had laid down in his paper, he was entirely at one with the remark as to the absolute necessity for making an accurate diagnosis of the disease to begin with. He felt more and more the longer he lived that in accurate diagnosis and knowledge of the natural history of disease they were pursuing the only sensible and legitimate method of being in a position to help their patients. Having made the diagnosis and having studied the disease intimately, not merely in its high

lights and deep shadows, but in its half-tones as well, precisely the same process of study ought to be applied to drugs. Although the high lights or dark shadows sometimes produced a brilliant result in the shape of a key-note symptom, they certainly did not furnish the most satisfactory help in the ordinary daily round of prescribing. Having studied the disease, he thought the proper plan was to go to the *materia medica* and find the medicine which had the same method of evolution as the disease; this done, many diseases would be found to be curable by single drugs, not only in a phase which might last an hour or two, but in a cycle of phases which might last for days or weeks, for the reason that there were drugs which presented these series of phases in their natural history. That plan was satisfactory to the patient because it succeeded, and it was satisfactory to the doctor because it appeared to him to be the obvious way of prescribing. In this way the necessity for the routine use of a repertory was obviated. Some doctors found a few prominent symptoms, and immediately sat down and consulted the repertory and gave a drug merely to get rid of those symptoms. In his opinion this would be entirely unnecessary if doctors knew their disease and then knew their *materia medica*. If doctors began by learning the ground work on some such plan as that laid down by Dr. Hughes, and then filled in the details, coming afterwards to the cyclopædia and learning the mode of evolution of the symptoms of a drug, they would be really in a scientific position. In connection with the question of the relation of influenza to gout, he would like to enquire whether it had never occurred to the author that gout could be obtained with a broken leg, or, indeed, by anything which condemned a naturally active man for two or three weeks to a life of inaction; influenza caused it for that reason, and for no other, and he (Dr. Blackley) had seen it occur constantly in gouty patients as a sequel to influenza.

Dr. McNISH said that his invariable practice in an ordinary case of disease was to thoroughly examine the patient. An accurate diagnosis of the life history, if possible, and the cause of the disease is essential. As a rule, to find the *simillimum* in most cases was something like a problem in mathematics. Doctors had to exercise a good deal of ingenuity to ascertain the facts, and even then they often entirely failed to give the right remedy for the condition. One important element had not been mentioned, namely, the importance of the sequence of the symptoms of the patient, a point which had been thoroughly dealt with by Dr. Ord, who had devised a means of obtaining the *simillimum*

by such a method. But, unfortunately, the value of the different symptoms was not the same, and one fault of the dictionaries was that the symptoms of each drug were always described in a certain order, *e.g.*, beginning with the mind, &c., and the symptoms were all assumed to be of equal value.

Dr. GOLDSBROUGH said that, although he had not heard the paper, he desired to offer a few observations on the author's work in general. It seemed to him that Dr. Clarke was not critical enough in his work on homœopathy. He did not think homœopaths could be too careful of their own methods, and that the further they pushed criticism the better the result would be. A doctor conducting a private practice might be satisfied with his own methods, but that was a different thing from when he tried to convince colleagues who were using different methods. What a man was satisfied with himself was not necessarily satisfactory from the general homœopathic standpoint, and in this way, it seemed to him, Dr. Clarke's general work was not quite convincing. He desired to see the author more critical of his own methods before he asked other homœopaths to follow them. For instance, with regard to the cases brought forward in the little book presented to the world by Dr. Clarke on the nosode of whooping-cough, the author formed a generalisation upon them that the nosode pertussin was the right remedy for whooping-cough in general. To his (the speaker's) mind, however, the cases brought forward were not convincing enough for him to depart from the old and well-tried practice which had been used in homœopathy for a hundred years in order to use the new nosode for that particular disease; the cases were not sufficient in number or in variety of detail for him to leave the old and well-tried remedies.

Dr. CRONIN said that he was brought up under Dr. David Wilson, and on three days a week used to sit with him in a loft from five o'clock in the morning till nine o'clock working with the repertories; and the success of Dr. Wilson's practice was well known. The majority of his cases were chronic cases; he used to investigate the diathesis first, and then get on to the diagnosis more, according to the symptomatology, referring constantly to the repertories. He was advised to study a medicine a day every day of the week, Sundays included, and by that means he was always ready to meet the symptoms of any case which came before him. By adopting the treatment he had described, all the minor symptoms were cleared away, and the real characteristic symptoms remained, which could be cured

with the proper drug. He had worked on those lines for forty years, and was satisfied with the results.

Dr. DEANE said that he had been consulted by an officer of the Indian Medical Service as to what course he should adopt in learning something about homœopathy. He advised him that the first thing he ought to do was to get at the genius of the drugs, and, having learned that, to study the symptomatology more accurately. In his opinion there was only one book in the English language from which any one could commence the study of homœopathy properly, namely, "Hughes' Pharmacodynamics." He had studied the "Cyclopædia of Drug Pathogenesis" and "Clarke's Dictionary of Materia Medica," and in the latter there was an absence of a grasping of the genius or broad action of a drug. A man in busy practice, or an army doctor, had to retain a view of the genius of drugs in his mind and carry half a dozen medicines in his pocket. He (Dr. Deane) originally learnt his homœopathy from Dr. Yeldham, who told him that the longer he lived the fewer drugs he used; and he was positive that doctors would carry on a much more profitable practice with a dozen medicines which they had thoroughly verified from "Hughes' Pharmacodynamics" than in any other way. In his opinion repertories, without exception, should be burnt, because they contained a conglomeration of unreliable symptoms, jumbled up anyhow, without sequence or order. For a young fellow beginning homœopathy, the best thing he could do was to avoid dictionaries and cyclopædias, and stick to "Hughes' Pharmacodynamics and Therapeutics."

Dr. MILLER NEATBY said he had been much interested in what Dr. Cronin had said about his old physician, Dr. Wilson, who he believed had a wholesome contempt for thermometers and other usual instruments of the medical profession; but there was no doubt he was a genius. He thought sufficient attention had not been focussed on the diagnosis of the diathesis. Although he had not had very much experience of homœopathic practice, he had been particularly struck with the fact that patients, time after time, said they felt very much better, although there was no obvious improvement in the local condition. He therefore felt sure that homœopaths would be erring from the right way if they neglected the study of diathesis.

Dr. ASHTON asked Dr. Clarke whether he would always use Koch's tuberculin in such a case as the one he described, or whether, if he knew the patient had suffered from influenza, he would use the nosode of influenza, or any other nosode. He

desired to emphasise Dr. Miller Neatby's remarks on diathesis, because probably the tuberculin in the case referred to had some similitude to the diathesis, and the drugs used afterwards for the treatment of the symptoms perhaps acted more successfully for that reason. He thought the study of diathesis was really included in one of Dr. Clarke's four kinds of diagnosis.

Dr. HAWKES, before calling upon Dr. Clarke to reply, said he was perfectly convinced from his past experience that the best advice to give a man coming from allopathy who wished to study homœopathy was, to refresh his memory and extend his knowledge by reverting to his toxicological studies. The second point he wished to emphasise was that they were not discussing names of persons, and he thought they ought to be avoided as much as possible. It would be within the recollection of everyone, however, that the pilot who helped Burnett out of the quicksands and rocks was Hughes, with his "Pharmacodynamics," although it was not necessary to discuss how far he kept within such limits afterwards.

Dr. CLARKE, in reply, said it might not be known to everyone present that he owed his introduction to homœopathy to the President. When he was in Liverpool Dr. Hawkes took him to the dispensary and presented him with the *implementa homœopathica*, and he at once selected out of them "Hughes' Pharmacodynamics." He hoped nobody thought he in any way disparaged that work. The only thing he said about it was that it was a partial work; it was not the body and bones of homœopathic practice, although it was taken as a complete work by practitioners of Colonel Deane's standing. It was exactly six years to a day—it was July 4th, 1900—since he signed the preface to the first volume of his "Dictionary of Materia Medica," and he was sorry that in all that time it had failed to convince Colonel Deane of the necessity of its existence, although he was happy to find that a good many of the speakers had discovered there was some good in it. In reply to Dr. Ashton, he found tuberculinum to be the antidote in the late and more chronic effects of influenza. For the acute conditions of influenza he used *influenzenum* very largely. Burnett struck out a great line when he discovered that tuberculin or bacillinum, which was what he mainly used, was antidotal, not so much to acute tuberculosis as to what he called "consumptiveness," where very likely there was no actual tubercle present, but where there was a tuberculous taint in the constitution. It enabled Burnett to do a large amount of good work in a number of cases which were not otherwise touched by

the apparently indicated remedies, exactly in the same way that Hahnemann found that the non-antipsoric remedy did not meet psoric cases. The value of that was that it saved an enormous amount of trouble if one grand line of correspondence in a certain set of cases could be obtained. Homœopathy was essentially the art of individualising, but when the practitioner has first individualised he may then generalise. The fault of generalising works on homœopathy was that they began at the wrong end, and did not take those who relied on them to the right end. Dr. Hughes built a magnificent bridge over to homœopathy, but it was just as easy for people to go backwards over the bridge as it was to go forwards, or to stay on the bridge and not go into the Promised Land, as Dr. Cronin had mentioned the Old Guard did. He strongly held that homœopaths ought to be free to follow any line they liked in the homœopathic arena. There was scope enough for every species of talent, and no man had the right to attempt to limit others to his own particular plot of ground. The value of generalisation in homœopathy was enormous, and it must be done, but they must individualise in the last resort if the generalisation failed. The remark Dr. Jagielski made on the necessity of correct thinking, expressed a very great truth. Homœopaths were apt to think half allopathically and half homœopathically, and until they learned to think exactly homœopathically they would not make as much headway as they might. The President had said that they had been referring to principles and not names. It was only as names presented principles that they were brought forward. Dr. Goldsbrough had very correctly said that any man who presented his work to the public submitted it to criticism, and he was very much obliged to that gentleman for the remarks he had made about his (Dr. Clarke's) work in general. There was a good deal to be said for "victorious analysis" and victorious criticism. He had not the smallest objection to anybody analysing his work up to the hilt; but there was also a very great deal to be said for what might be called positive work. Negative work simply consisted in pulling to pieces, and positive work, which was his branch, was building up. He left the analysis to Dr. Goldsbrough and his friends who had criticised his (Dr. Clarke's) work on whooping-cough. He gave his little book to the public for reasons he had stated clearly in the preface. As Burnett gave the key to the use of chronic nosodes, so he (Dr. Clarke) had given the key to the use of acute nosodes in the brochure on whooping-cough, and from that one example the rest could be learned. It was true only seven cases were published,

but he had had a great number since, and in due course he might publish them. In reference to the sequence of symptoms he recognised that this was very important, but it was not easy to get details of the sequence from the patients.

CASES AND SPECIMENS EXHIBITED AT VARIOUS MEETINGS.

CASES.

*Hypertrophy of Finger.*¹

A WOMAN whose ring finger on the left hand showed enormous overgrowth, brought about apparently by the constriction caused by her ring. The whole of the tissues, bony as well as soft, seemed to be greatly hypertrophied, as the ring was embedded as regards three-fourths of its circumference by soft structures which had grown over it. The condition had lasted for some years, and a previous attempt had evidently been made to remove the ring, which was cut through at one point. This procedure had given so much relief that the ring was now freely movable and could be rotated in its bed, but each movement caused sharp shooting pains down the radial side of the affected finger, as though the nerves on that side were exposed to contact of the ring.

Dr. Ellis kindly photographed this almost unique condition, of which a permanent record is thus in existence. The ring was later on successfully removed, but the hypertrophied condition of the finger persisted.

*Undescended Testicle with Hypertrophied Mamma.*¹

A boy, aged 12, with undescended left testicle, who also showed enormous development of the left mamma. There were no glandular swellings in the axilla. The connection between the two conditions and the possibility of restoring the balance of growth and development by surgically treating the undescended testicle, was the source of an interesting discussion when the case was exhibited.

*An Abdominal Case.*²

Dr. Reed reported the case of a girl, aged 20, in whom he had performed a laparotomy for the relief of a severe and very persistent pain in the right inguinal region.

¹ Exhibited by Dr. ERNEST HAWKES, at the Liverpool Branch, November 9, 1905.

² Exhibited by Dr. CASH REED, at the Liverpool Branch, January 11, 1906.

On opening up the abdomen it was noticed that (a) the appendix was enormously elongated and attenuated, and (b) that the right ovary was slightly enlarged and prolapsed. The appendix was removed as it was thought that owing to its length it might give rise to future trouble, but the ovary was not touched, owing to the age of the patient and other circumstances. The patient made an excellent recovery, but the pains were not in any way relieved. Since her discharge the patient had, it seems, come under the observation of another gynaecologist who had also done laparotomy, though the exact nature of the initial operation done by him was not known, but the point of interest lay in this, that he had noticed during her operation that there was a swelling in the lower end of the right kidney, and that this swelling was later on found to be due to the presence of a renal calculus, and that the subsequent removal of which had completely removed the pain complained of. Such a case illustrates the necessity for prolonging investigation into the improbable as well as probable sources of *materies morbi*.

*Hermaphroditism.*¹

Dr. Hayward reported the main points of a case at present under treatment in hospital.

It was that of an apparent hermaphrodite, which condition, on close inspection, was found to result from hypospadias, together with rudimentary development of the entire genital folds. The patient, who was a footman, had for some months suffered considerable pain from a small lump which had appeared in his left groin.

It was decided to cut down and remove this tumour, and on doing so it was found to be a rudimentary testicle. It was interesting to note that the patient's breasts were very much larger than usual in men, and that the disposition of the pubic hair was much more like what obtains in the female than in the male.

SPECIMENS.

*Carcinoma of Descending Colon.*²

Five inches of descending colon removed for columnar-celled carcinoma in a man, aged 48. The tumour could be readily pal-

¹ Reported by Dr. CHARLES HAYWARD at the Liverpool Branch, May 10, 1906.

² Exhibited by Mr. KNOX SHAW, November 2, 1905.

pated abdominally. The divided bowel was anastomosed by end to end simple suturing.

The patient, whilst convalescing well, died suddenly on the ninth day.

Post mortem.—He was found to have adherent pericardium.

*Prostate and Calculi.*¹

Prostate and calculi removed suprapubically from the bladder of a man, aged 67. He suffered from cystitis, and was compelled to use a catheter always. Ten years previously he had had a tumour removed from the bladder at another hospital. The left half of the prostate enucleated easily, but the right half with great difficulty. The patient collapsed and died an hour and a half after the operation.

*Uric Acid Calculus.*²

A uric acid calculus passed *per vias naturales* after the usual symptoms, colic and hæmaturia. Complete recovery.

*Hæmatoma.*³

A lutein hæmatoma associated with coccygodynia. Recovery. A microscopic section of ovary from the same case, showing excess of lutein cells.

*Malarial Parasite.*⁴

A blood-stained film showing hæmamoebæ of Laveran from a case of malaria contracted in South Africa.

*Melanotic Sarcoma.*⁴

A microscopic section of melanotic sarcoma of the skin of the abdomen.

*Oxalate of Lime Calculus.*⁵

A calculus of pure oxalate of lime passed through the urethra.

*Uterine Myoma.*⁶

Large uterine myoma requiring radical operation after myomectomy thirteen years ago. Hysterectomy. Recovery.

¹ Exhibited by Mr. KNOX SHAW, November 2, 1905.

² Exhibited by Dr. ROBERSON DAY, November 2, 1905.

³ Exhibited by Drs. VINCENT GREEN and EDWIN A. NEATBY, November 2, 1905.

⁴ Exhibited by Drs. BYRES MOIR and FRANK WATKINS, January 4, 1906.

⁵ Exhibited by Dr. FRANK WATKINS, January 4, 1906.

⁶ Exhibited by Dr. BURFORD, February 1, 1906.

*Uterine Myoma.*¹

Uterine myoma removed on account of pelvic pain. Hysterectomy. Recovery.

*Uterine Myoma.*¹

Uterine myoma removed on account of intractable hæmorrhage. Hysterectomy. Recovery.

*Ovarian Cyst.*¹

A strangulated ovarian cyst removed on account of acute abdominal symptoms. Ovariectomy. Recovery.

*Double Ovarian Cystoma.*¹

Double ovarian cystoma with malignant infiltration. Ovariectomy. Recovery.

*Dermoid Ovarian Cyst.*¹

Dermoid ovarian cyst causing pelvic pain. Ovariectomy. Recovery.

*Hydrosalpinx.*¹

Hydrosalpinx causing persistent pelvic pain. Salpingectomy. Recovery.

*Carcinoma Cervix Uteri.*¹

A carcinoma of the cervix uteri of an epitheliomatous nature. Vaginal hysterectomy. Recovery.

*Hydrosalpinx.*¹

Hydrosalpinx the focus of acute abdominal and pelvic peritonitis. Salpingo-oöphorectomy. Recovery.

*Uterine Myoma.*¹

Uterine myoma with purulent cyst cavity. Hysterectomy. Recovery.

*Radiograph of Fractured Fibula.*²

Dr. Reed showed the negative of an X-ray photograph which had been taken of the ankle of a patient in whom the subjective symptoms, following upon a severe traumatism, all pointed very strongly to fracture, whilst, objectively, there were none of the usual fracture symptoms present. The plate showed a longitudinal split in the tip of the fibula without any displacement.

¹ Exhibited by Dr. BURFORD, February 1, 1906.

² Exhibited by Dr. CASH REED, at the Liverpool Branch, January 11, 1906.

Uterine Fibromyoma with Chart showing Tachycardia.¹

F. A., aged 41 years, had been under treatment in the out-patient department for some time for myoma uteri.

When admitted as an in-patient, her chief symptoms were constant abdominal pain, dysmenorrhœa and dysuria.

Dr. Neatby performed abdominal hysterectomy. Five days after operation patient complained of pain over the cardiac region. On examination the heart was found to be dilated. Pulse rapid and irregular.

After the administration of lachesis 12, the pulse rate immediately returned to the normal, and the signs of dilatation disappeared.

Multinodular Uterine Fibromyoma.²

Miss B., aged 46 years, a patient of Dr. Midgley Cash's, was operated on by Dr. Neatby for myoma uteri.

She had suffered from right iliac pain and breathlessness.

At the operation, abdominal hysterectomy, the tumour was found to contain multiple myomata. Its removal was a somewhat tedious proceeding, as it was deeply embedded in the pelvis. Patient made an uninterrupted recovery.

Calculous Pyonephrosis.³

This specimen was removed during life from a young woman who had had for a considerable period chronic pyelitis. Associated with the pyelitis there was an obvious swelling in the right loin.

At an operation, finding a cystic kidney with a small stone blocking the ureter, and no kidney substances of any mark at all, the patient was nephrotomised, and went out of the hospital perfectly well.

Carcinoma of Pancreas with Microscopic Section.⁴

Mr. Frank Watkins remarked, concerning this specimen, that it had been possible to diagnose the disease during life. Dr. Goldsbrough, who saw the case in consultation with him, came to the same conclusion. Cammidge's crystals were found in the urine, and on a *post-mortem* examination being made it was found that the pancreas was infiltrated with a growth, and that there

¹ Exhibited by Dr. E. A. NEATBY, February 1, 1906.

² Exhibited by Drs. MIDGLEY CASH and EDWIN A. NEATBY, February 1, 1906.

³ Exhibited by Mr. KNOX SHAW, March 1, 1906.

⁴ Exhibited by Mr. FRANK WATKINS, March 1, 1906.

was also a secondary deposit in the interior wall of the stomach. On a section being made, hæmorrhages were found in the secondary deposit. The present case was additional evidence in support of the views as brought forward recently (see JOURNAL, vol. xii., p. 274) as to the cause of pancreatic hæmorrhage in general. While the case now recorded was under his observation a discussion was taking place in the correspondence columns of the *Lancet* as to the cause of gray-white stools in cases of pancreatic disease and obstruction. Years ago it was supposed to be due to the absence of bile, but it had been shown in many cases that there was no obstruction of the bowel whatever, so that that could not be the case. It had recently been proved that it was due to the presence of fat in a liquid, solid or crystalline, state. That could be demonstrated very easily by abstracting the fat by means of ether. He had in a tube some of the stool of the ordinary gray-white colour from the patient; he had abstracted the fat, and it would be seen that the stool had turned into the ordinary dark-brown-colour fæces. But that fat was not always the cause of the colour was shown by a case of Dr. Eppe's, in which Dr. Ham and the speaker abstracted the fat from the stool, and it still retained its grey-white colour.

*Hydrosalpinx.*¹

The origin of the hydrosalpinx in this specimen appeared to have been a somewhat unusual one. Five or six years ago the patient was operated on for carcinoma of the cervix. The uterus was removed by vaginal hysterectomy, and the ovaries and tubes were found to be quite sound. The Fallopian tube on one side appeared to have fallen down to the floor of the pelvis, and become involved in the inflammatory action during healing, and the orifice thereby closed. Fluid then accumulated in the tube, forming a rather pretty specimen of hydrosalpinx. Recovery had ensued from a second operation.

*Bilateral Ovarian Hæmatoma.*¹

Bilateral ovarian hæmatoma with multiple small myomata uteri. Recovery.

*Radiograms of Knee.*²

Two radiograms, illustrating hyperextensibility of right knee in a girl of 16.

¹ Exhibited by Dr. E. A. NEATBY, March 1, 1906.

² Exhibited by Mr. C. J. WILKINSON, June 7, 1906.

REPORT OF THE COUNCIL.

THE session 1905-6 of the British Homœopathic Society opened on October 5, 1905, under the Presidency of Dr. A. E. Hawkes, of Liverpool, elected at the last annual assembly, who gave an interesting address entitled "Provincial Reflections," being a sketch of the progress of medical science during the last thirty-five years. Eighteen papers in all have been read this session; most of these were short, three only occupying a whole evening. From the novelty of the subjects two of these deserve special mention, viz., a paper by Mr. Dudley Wright on the "Therapeutics of Light Energy," and one by Dr. C. E. Ham, introduced by Dr. Byres Moir, on the "Treatment of Tuberculosis and other Bacterial Infections by Vaccines made from the corresponding Micro-organisms, and regulated by Measurement of the Opsonic Power of the Blood." The discussions have usually been of considerable interest.

The death of Dr. E. J. Hawkes, of Ramsgate, was announced at the March meeting, and a vote of condolence was passed.

The Society has also lost by resignation the following members: Dr. Arnold, Dr. Lucas Hughes, and Dr. Prowse. Four new members have been elected: Dr. Hayes, of Leeds; Drs. Eadie and Barnes, of London; and Dr. Greenwood, of Liverpool.

Early in the Session the president (Dr. Hawkes), Dr. Blackley, Dr. Madden and Dr. Neatby were appointed a committee to represent the Society in the arrangements for the International Congress.

The Society has had the pleasure of welcoming visitors from America and the continent of Europe to some of its meetings, of whom Dr. Krauz gave a short sketch, in excellent English, of the recent progress of homœopathy in Germany.

A number of new modern books have been added to the library. The circulation of magazines has been carried on amongst those members who have asked for them. The magazines have been sent off regularly by the Society's officials, but very few of them reach the librarian after circulation.

The number of unpaid subscriptions is nine, and of these two are of three years' standing. Several fresh members have

THE BRITISH HOMOEOPATHIC SOCIETY.

Dr. Cr.
BALANCE SHEET—SESSION 1905-1906.

RECEIPTS.		EXPENDITURE.	
	£ s. d.		£ s. d.
To Balance in Hand	By Rent ..	.. 25 0 0
„ Dividends on Consols	„ Printing, less advertising ..	.. 95 15 6
„ Subscriptions	„ Reporting ..	.. 23 2 0
„ Sale of Publications	„ Honorarium to Editor ..	.. 10 10 0
„ Half cost of Plates	„ Library ..	.. 24 0 0
		„ Postage and Stationery ..	.. 6 18 0
		„ Indexing Account ..	.. 28 0 0
		„ Refreshments ..	.. 5 10 0
		„ Petty Cash ..	.. 2 11 8
		„ Balance ..	£221 7 2
			63 5 8
			£284 12 10

Audited July 4, 1906.
T. G. STONHAM, M.D.

JNO. G. BLACKLEY, *Treasurer,*

adopted the method of paying by banker's order, thereby saving labour and expense to the Society.

It is with much regret that the Council record a serious accident to the president in the month of May, which marred the unbroken record of his attendances at the meetings of the Council and the Society.

REPORT OF THE INDEXING COMMITTEE.

In presenting their final report the Indexing Committee have to announce the practical conclusion of their labours. They had hoped and expected to have submitted a specimen copy of the "Index" as it at present stands in print, but a few typographical corrections alone remain to be made, after comparison with the originals, and hence the fully-projected document has not quite left their printer's hands.

Practically the whole work is, or will be in a few days, ready for issue. The committee do not think all the Fellows and members are fully aware of the very great importance and value of the forthcoming publication. It unlocks in a moment the treasures hidden and embedded in the whole of British Homœopathic periodical literature. Every reported case of the cure of disease by homœopathic remedies has been read and noted. Every reported instance in which any homœopathic remedy has acted remedially has been inspected and allotted to its proper place in the Index. Every essay or any important branch of homœopathic treatment has been looked over and referred to in the forthcoming Index. Thus all the labour of our colleagues, present and past, that have found their way into homœopathic periodical literature are rendered supremely easy of access by the medium of the Index.

The homœopathic literature that has thus been digested consists of:—

- (1) *The British Journal of Homœopathy.*
- (2) *The Monthly Homœopathic Review.*
- (3) *The Homœopathic World.*
- (4) *The Journal of the British Homœopathic Society.*
- (5) *The London Homœopathic Hospital Reports.*
- (6) *The Homœopathic Annual.*
- (7) *The Homœopathic Times.*

All up to 1896.

Our eminent colleague, Dr. Dudgeon, in collaboration with the undersigned, was engaged on the work up to his death ; since then we have continued the work of collaboration alone.

The Committee ask :—

(1) That this meeting vote the expenses incurred since the last subsidy should be forthwith discharged by the treasurer ; and

(2) That the Council be instructed to use their discretion with regard to the method of publication of the work, whether by the Society itself or a private firm.

(3) That the publication should take place with no unnecessary delay.

GEORGE BURFORD,
WASHINGTON EPPS,
Members of the Indexing Committee.

SOCIETY NEWS.

NEW FELLOW.

At the Annual Assembly held on July 5, Thomas George Stonham, M.D.Lond., M.R.C.S., a member of the Council, and a member of the Society since 1889, was elected a Fellow of the Society.

OFFICERS FOR THE SESSION 1906-7.

At the Annual Assembly, held on July 5, the following officers were elected for the ensuing Session :—

President : John H. Clarke, M.D.

Vice-Presidents : William Cash Reed, M.D., David Macnish, M.A., M.B.

Treasurer : John G. Blackley, M.B.

Council : (*Ex-President, ex-officio*) Alfred E. Hawkes, M.D. ; (*Fellows*) George Burford, M.B., Byres Moir, M.D., C. Knox Shaw, T. G. Stonham, M.D. ; (*Members*) R. M. Le Hunt Cooper, M.D., James Searson, M.D.

At a meeting of Council, held subsequently to the Annual Assembly, the following officers were elected :—

Secretary : Edwin A. Neatby, M.D.

Editor : Giles F. Goldsbrough, M.D.

Librarian : J. R. P. Lambert, M.D.

Secretaries of Sections.

Materia Medica and Therapeutics : T. G. Stonham, M.D.

General Medicine and Pathology : A. Speirs Alexander, M.D.

Surgery and Gynæcology : Vincent Green, M.D.

LIVERPOOL BRANCH OFFICERS FOR 1906-7.

President : James Watson, M.B., C.M.

Vice-President : John W. Ellis, M.B., Ch.B.

Secretary and Treasurer : James L. Hawkes, M.B., Ch.B.

Representative on Council : Alfred E. Hawkes, M.D.

OBITUARY.

George Wyld, M.D.

The death of Dr. George Wyld, the oldest member of the British Homœopathic Society, is announced as having taken place on June 27 last at the age of 85 years. Dr. Wyld was elected a member in 1851. His tall and handsome figure had been missed from the meetings of the Society for a good many years, but in the 'seventies and early 'eighties he was frequent in his attendance, and in 1876 held the office of Vice-President; that would be before the long presidency of the late Dr. Quin (1844-78) had come to an end. Dr. Wyld was distinguished for independence of thought, and for the courage he displayed in following up his opinions in life, even though he had to suffer thereby. He took much interest in spiritualism, in politics, and in theosophy or theology. He was the author of numerous works on non-medical subjects.

Editorial Note.—The Editor regrets an incorrect initial attached to the name of the author of books on Cholera and Plague, the receipt of which was acknowledged in the July number of the Journal. The name is S. C. Ghose, not S. H. Ghose.

SUMMARY OF PHARMACODYNAMICS AND THERAPEUTICS.

Extracted from Exchange and other Journals by the Editor, in collaboration with J. Galley Blackley, M.B., and T. G. Stonham, M.D.

Atropia in Gastric Pain from Hyperchlorhydria.—Dr. Clarence Bartlett, in an article on some therapeutic uses of atropia, praises this drug as a reliever of dyspeptic conditions with much pain, and gives several cases, of which the following is one. Mr. F., aged 27, had suffered from disordered stomach since the age of 12. Had been worse lately and complained of a heavy feeling in the stomach after food. Sometimes he has a violent pain soon after eating. He is a great smoker, consuming never fewer than twelve cigars daily, and in addition chews tobacco. No vomiting or nausea. Has been treated by lavage for four months without benefit. Bowels regular, twice daily. Much flatulence. Stomach feels greatly swollen after meals, even when they are spare, and may begin to swell even while he is eating. Gaseous eructations, tasting of food; sometimes sour eructations. Indulges to excess in sexual intercourse. Physical examination negative. Examination of gastric contents showed decided hyperacidity. Atropia, gr. $\frac{1}{100}$ *ter die*, was prescribed. Improvement was prompt, and after three months' regular treatment he was quite well. A relapse a year later was successfully met by returning to the atropia. (*Hahnemannian Monthly*, July, 1906.)—T. G. S.

Calcarea Carb. in Renal Colic.—S. M., female, aged 16, had attacks of renal colic every three to five weeks, which were soothed by morphine till the calculi had worked down the ureter. She had been advised to have the offending kidney surgically treated. She was a brunette, lackadaisical, pallid, with a hand like a wet dish rag; fond of ham, chalk, and slate pencils. When seen she was having one of her renal attacks. R. Calc. c., C.M., a powder

every fifteen minutes. The attack halted and cleared away in an hour. The urine for several days afterwards was turbid, with calcium carbonate and phosphate deposit. Several powders were left with instructions to take them if necessary, but six months later no repetition of the attacks had occurred, and a year later she had still been free from them and was much better in general appearance and health. (F. W. Shedo, M.D., *Hahnemannian Monthly*, June, 1906.)—T. G. S.

Constipation cured by Psorinum.—Mrs. B., aged 37, nullipara, not well since typhoid fever ten years ago. A history of several attacks of membranous colitis. Tenderness over the whole abdomen, especially cæcum and sigmoid flexure. For a year past no stool without laxatives or enemata. Despondent, tearful, sensitive to fancied slights. Always tired. Had lost 25 lbs. in weight. Subnormal temperature in morning, slightly raised in the evening. Pulse 110 to 130. Menses regular, scanty, lasting two days; insomnia. Stool often covered with fine sago-like grains and with mucus. Had a small goitre. A flat, dry, scaly eruption on scalp, scarcely redder than the surrounding skin, together with her despondency, led to the selection of psorinum 200, which was given once a week and rapidly insured a daily evacuation and much improvement in general health. (G. Wilson, *American Physician*, June, 1906.)—T. G. S.

Hydro-electric Baths in Different Cardio-vascular Affections.—MM. Weil and Mougeot (of Royat) have been examining the effects of hydro-electric baths, with triphase currents, in different cardio-vascular ailments, and arrive at the following conclusions: They produce (1) very constantly a notable diminution of arterio-capillary pressure; (2) three times out of four, a considerable diminution of arterial pressure, in the fourth experiment it remained constant; (3) modifications in tracings of the radial pulse, consisting in (a) increased amplitude of the systolic wave, (b) accentuation or reappearance of the wave due to arterial elasticity, (c) accentuation of diastole; (4) no increase in amplitude of the capillary pulse; (5) diminution of the cardiac area measured with the orthodiagraph, most unmistakably when the heart is dilated; that is to say, diminution in volume of that organ.

These different modifications prove that the bath with three-phase currents causes a lessening of the resistance opposed by the arteries to the blood wave and favour the depletion of the

heart, raising the hope that a series of three-phase baths offers a rational treatment for hypertension. (*L'Art Médical*, May, 1906, p. 378.)—J. G. B.

Pernicious Anæmia successfully treated by Radiotherapy and Injections of Antitoxic Serum.—MM. Rénou and Tixier have recently had under treatment a woman, aged 68, who was admitted to hospital with 1,090,000 red corpuscles per c.mm.

(1) For twenty-one days (from October 8 to October 29) Fowler's solution was exhibited in the usual manner (doses progressively increasing and then decreasing). The results were that the erythrocytes fell from 1,090,000 to 790,000, and the weight from 44 to 43 kilogs.

(2) From October 29 to November 19 radiotherapy alone (five séances of fifteen to twenty minutes each). The red globules rose from 790,000 to 920,000, the general condition was immensely improved, and she put on 0.5 kilog. in weight.

(3) From November 23 until December 9 the treatment was mixed; three séances of radiotherapy and four injections of antidiphtheritic serum (45 cc. in all). Erythrocytes rose from 920,000 to 1,315,000, and the weight from 43.5 to 45 kilogs.

(4) From December 12 to February 25 antitoxic treatment alone. During this period the patient received fourteen injections, comprising 265 cc. of antidiphtheritic serum. The tale of red corpuscles rose steadily to 2,545,000, and the hæmoglobin to 90 per cent. of normal. The body weight rose to 49.5 kilogs.; the general condition became excellent; the gastro-intestinal functions were regular and the patient considered herself as cured. In spite of the heavy doses of the serum there was neither erythema nor any important local reaction. The injections were usually given three at a time, each of 20 cc., during one week, and these were followed by a fortnight's rest, with the curious result that the hæmological formula and body weight tended to rise during the week of treatment and to remain stationary, or even yield a little, during the weeks of repose. Moreover, the erythrocytes were found notably increased within two hours of the injection, they attained their maximum between the fourth and fifth hour following, then diminished somewhat, but twenty-four hours later the number was found higher than it had been before the injection of serum. The influence of the injections upon the leucocytes was also constant and remarkable. The polynuclear eosinophiles would rise from 5 to 19 per cent., from 6 to 10 per cent., and from 5 to 8 per cent., during the hour following the three injections. (*L'Art Médical*, May, 1906, p. 374.—J. G. B.

Puerperal Eclampsia.—*Treatment.*—In a series of papers on convulsions, with a discussion thereon, the various points in the treatment of puerperal eclampsia are well brought out. In view of toxæmia as cause the first practical point in treatment is *elimination* all through. The skin should be kept active, the bowels thoroughly open, and the diet directed in accordance with this view by the free use of fruit, cereals, vegetables and modifications of milk. In more severe cases milk alone is the safest diet. The hot wet pack, saline intravenous injections, venesection, chloroform anæsthesia, oxygen inhalation, or tincture of veratrum viride, and the earliest possible delivery, are recommended as measures at the onset of the attacks (Dr. E. P. Ruggles). Dr. George H. Earl gives the following as his general plan of treatment. The administration of a remedy like belladonna, the hot wet pack, the introduction of large amounts of water by the stomach, bowel, under the skin and in the veins, and in extreme cases the extraction of blood, replacing it by saline, and chloroform to control the severity of the convulsions. Dr. Earl gives four successful cases treated after this manner. The above plans of treatment are criticised by Dr. Caroline C. Hastings, who maintains that the true antidote to the condition is the homœopathically indicated remedy, and she quotes thirteen cases treated symptomatically at the Talitha Cumi Maternity Home without the loss of a case. None of these cases received morphia or a wet pack, or were bled. Only one had ether anæsthesia. The following are given as indications in different cases where the remedies proved successful. In stertorous breathing, coma, with hot sweat, opium c. m. In a case occurring after delivery in violent paroxysms with bluish face, the convulsions beginning in the eyelids, extending to the face, and then generally, hyos. c. m. in single doses after the attacks completely controlled them after three doses. Helleborus is indicated when there is rolling of the head and boring into the pillow with strabismus. In two cases stramonium proved successful, the indications in one being graceful gyratory motions before the fit, and in the other a frightened look in going into and coming out of the fit. Bell. c. m. controlled in a case where there was flushed face, widely-dilated pupils, and convulsion following each contraction of the uterus. In one case, opium 4x gave very marked results, and with complete success. (*New England Medical Gazette*, June, p. 270.)—ED.

Radium.—*Its medical value.*—Metzenbaum, after a careful study of medical literature and an extended clinical experience in

the use of radium, has arrived at the following conclusions as to its utility in medical practice.

(1) That lupus responds promptly to the action of radium, and that this result is obtained as readily as with the Finsen light or X-rays, and that the results seem permanent.

(2) That small epitheliomata without glandular enlargement heal rapidly under the action of the radium rays. The epitheliomata may be situated on the face, within the nasal cavity, mouth, pharynx, larynx, vagina, rectum, or bladder, provided the tubes of radium can be brought into intimate contact or close proximity with the diseased area.

(3) Rodent ulcers about the face and head respond better to the action of radium than to any known agent, excepting the X-rays, and the results are better than those usually obtained by surgical interference.

(4) Deep-seated malignant growths are beyond the influence of the radium rays.

(5) When tubes of radium are applied to old scars resulting from healed lupoid ulcers it causes them to lose their rough and fibrous appearance, and renders the area quite smooth and pliable, and more like the healthy tissue.

(6) The beneficial results obtained from radium have been equally good when using tubes of low activity as when using tubes of very high activity.

(7) Up to the present time radium is to be classed with the Finsen light, X-rays, and surgery in the treatment of lupus, and with surgery and the X-rays in the treatment of rodent ulcer and small epitheliomata. (Quoted in *Hahnemannian Monthly*, June, 1906.)—T. G. S.

Salicylate of Soda in Inflammatory Eye Diseases.—H. Gradel says that the disease in which salicylate of sodium has proved itself superior to any other therapeutic agent is iridocyclitis, due to traumatism with infection, as well as in sympathetic disease secondary to it. He has watched sympathetic inflammation from the day of the start to its termination in three patients treated with salicylate of sodium. All three recovered with perfect sight. (Quoted in *Hahnemannian Monthly*, August, 1906.)—T. G. S.

Yellow Glasses in Hyperæsthesia of the Retina.—M. Mottais, in a communication to the Académie de Médecine (May 27, 1906), advised the use of yellow glasses, of a tint determined by himself, in cases of retinal hyperæsthesia. He finds that

this colour gives in a high degree the sensation of clearness and, at the same time, of rest. Notwithstanding the intensity of the light, patients say that these glasses are soothing to the eye. The property possessed by yellow-coloured glasses depends upon the fact that they prevent the passage of the chemical rays, which are the most irritating to the retina. M. Mottais advises the same glasses as a protection from sunlight, from the incandescent gas-light, and, above all, from that of the electric arc-lamp; they are useless for artificial light produced by oil or petroleum. (*L'Art Médical*, May, 1906, p. 352.)—J. G. B.

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